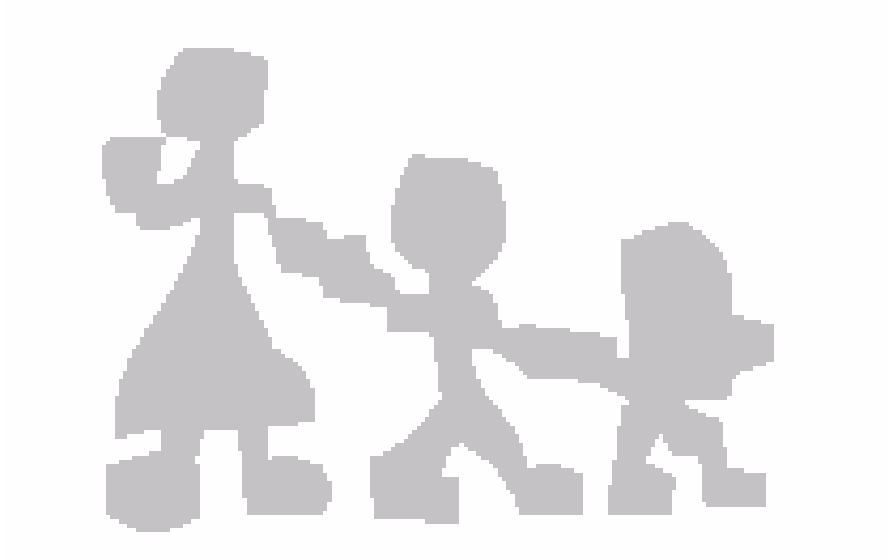
Parenting a Young Child with Behavior Problems

Parents' experiences before, during and after Webster-Stratton Parent Training



Jim Lurie and Graham Clifford

Barnevernets utviklingssenter i Midt-Norge.
Rapport fra brukerundersøkelsen knyttet til prosjektet "De utrolige årene" (Webster-Stratton programmet).

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Forfattere:	Jim Lurie og Graham Clifford
Oppdragsgiver:	Sosial- og helsedirektoratet
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Referat:	Dette er en studie av foreldres erfaringer med å oppdra barn med atferdsproblemer før, under og etter deltagelse i Webster-Strattons foreldreopplæringsprogram. Foreldre var fornøyde med programmet, og særlig med den positive samhandlingen med andre foreldre i samme situasjon. Dette hjalp dem til å få en nødvendig forbedring i deres selvbilde etter år med vanskelig relasjoner i familien. Mange foreldre lærte også nye oppdragelsesmetoder som hjalp dem til å samhandle med barnet på en mer positiv måte.
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Preface

This study has been carried out by The Regional Child Protection Research Unit in Trondheim with financing from the Norwegian Directorate for Health and Social Affairs (Sosial- og helsedirektoratet). It is part of a larger research initiative focused on the issue of small children with behavior problems which also includes a treatment trial of the Webster-Stratton Parent Training program and a screening study designed to measure the prevalence and distribution of these types of problems in Norway. This study is a qualitative analysis of the experience of parents raising children with serious behavior problems who have received help from the Webster-Stratton Parent Training program in Trondheim.

The study is based on interviews with 19 sets of parents who participated in this program in 2001 or 2002. Its aim is to find out about parents' experience raising a child with behavior problems and their views on the Parent Training program. These parents provided us with fascinating and detailed accounts of what it has been like living with a young child with serious behavior problems for them and their families, and shared their impressions of the Parent Training program. We thank them for their participation, and for their willingness to talk so openly with strangers about such a sensitive topic.

The study has been designed and implemented by two researchers at the Regional Child Protection Research Unit, senior researcher Jim Lurie, and Graham Clifford, who is professor at the Regional Center for Child and Adolescent Mental Health in Trondheim. Jim Lurie has had responsibility for supervision of data collection, for data analysis, for writing chapters 2 - 4 (the empirical findings), and for editing this report. Graham Clifford has provided supervision for the project, and written much of the interview guide and the first and last chapters of this report (chapters 1 and 5). We would also like to thank Anne Mørkved for her able assistance in carrying out and transcribing the interviews.

We hope this report will be of interest to those directly connected with the Webster-Stratton program, as well as to parents and others who are involved in the lives of children with behavior problems.

Trondheim, January 2005

Jim Lurie and Graham Clifford

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Summary

This study is designed to gain insight into the views and experiences of parents of children with severe behavior problems, who have participated in *The Incredible Years* program in Trondheim in 2001 or 2002. This program was developed in the US in the 1980s by Webster-Stratton and associates at the University of Washington to assist the parents of children aged 4 - 8 years in managing their children with severe behavior problems. The program has shown good results in the US and several other countries, and has now been tested in Norway in a treatment trial with 127 families in Trondheim and Tromsø. This study is based on interviews with 19 sets of parents who participated in this program in Trondheim in 2001 or 2002. Parents were asked about their experiences in raising a child with behavior problems from the time these problems first became visible until the time of our interviews in the fall of 2003, 18 - 24 months after they had completed Parent Training. The study is, therefore, both a user evaluation of Webster-Stratton Parent Training in Trondheim and a broader retrospective study of parents overall impressions of what it has been like for them and their families living with a young child with severe behavior problems over many years.

Parents were generally aware of their children's problems from an early age, often by the age of 3 - 4 years. Two types of behavior were especially characteristic of these children, and troubling to their parents – frequent, uncontrolled anger and aggression, and hyperactive, restless behavior requiring constant supervision. The children's behavior had serious consequences for their parents, themselves, their siblings, other relatives and eventually for the family's interaction with the outside world. Family life was disrupted, relationships between family members were often tense and dysfunctional, and parents had too little time for each other and for other children in the family. Parents struggled with feelings of responsibility, guilt, inadequacy, exhaustion, frustration and despair. They felt trapped in a vicious cycle of unacceptable behavior, ineffective parental responses, and escalating behavior problems. Families felt stigmatized and increasingly isolated. Parents were often unsure of the exact nature of the child's problems and what to do about them.

Though parents had often received some help prior to Parent Training from various community services including preschool, public health clinics, school counseling and child protection this help was usually not aimed at helping them to manage their child's difficult behavior, and was generally insufficient to achieve meaningful pro-

gress for the child or the parents. Families often had to wait several years from the emergence of the child's problems until they were referred to Parent Training, often after the child had started school. During this waiting period the child's problems tended to worsen. Preschool teachers were usually the first to confirm parents' concerns about the child's behavior, but usually did not refer families directly to Parent Training. Most referrals were made by school counseling and/or child protection services, and several families took initiative to contact the program themselves.

Parents were all satisfied with Parent Training, and particularly with the opportunity to interact with other parents who were in a similar situation. The parent groups were an important source of solidarity and mutual support and provided a valuable opportunity to exchange experiences, parenting strategies, and to discuss with others who understood what they were going through. The parent groups helped parents to increase their self-esteem, and to reduce their feelings of stigmatization and isolation. Parents were also satisfied with group leaders, mainly because of their personal qualities including warmth, empathy, enthusiasm, concern, and a nonjudgmental approach. Parents had mixed reactions to the teaching techniques employed during the sessions including video clips, role play and home assignments. Some felt that the sessions were too intensive, with group leaders pushing to complete the planned course content at the expense of sufficient time to discuss with other parents.

Almost all parents felt that they had understood the main principles of the program. These included the importance of positive parenting, paying more attention to, encouraging, and rewarding children's positive behavior, and ignoring negative behavior, and reducing the use of scolding, and more severe forms of punishment. It is less clear how well parents were able to master the parenting techniques presented, and to use them consistently and effectively with their children, also after the training was over. The majority of parents did feel that they had improved their parenting skills and were able to use them at least to some degree with their children. Others gave vague descriptions of the actual methods they had learned, and some admitted that they did not use the new techniques. Parents also described considerable differences with regard to improvements in their child's behavior before and after Parent Training. While some parents saw noticeable improvements which they attributed at least in part to the effects of Parent Training, others reported little or no improvement. These differing changes in child behavior can be explained in part by the method used to select the parents interviewed for this study.

Parents' situation at the time of the interview (approximately 18 - 24 months after completing training) also varied greatly. Most parents continued to enjoy the improved morale which they had acquired during parent training. Some parents tended to be optimistic about the future and about their ability to handle future challenges, particularly parents who had seen improvements in their child's behavior. Other parents were more pessimistic, and were particularly concerned about what would happen as their child grew older and encountered the increased risks and temptations of adolescence. Many parents wanted additional help with their child. Some wanted a follow-up parent training program, and some wanted help to maintain contact with other parents in their group. Others wanted other types of help including more support from school counseling and extra resources for the child at school.

Conclusions from this study are as follows:

1. *Parents were generally the first to become aware of their child's problems and usually while the child was 3 - 4 years of age or earlier.*

2. *Raising a young child with serious behavior problems placed serious burdens on parents and other family members, especially siblings.*

3. *Most families were in contact with various community services before starting Parent Training but these were unable to provide parents with the type of systematic assistance which they needed to raise their children more appropriately.*
4. *Most families had to wait several years or more before they were referred to Parent Training, during which time the child's problems often became more serious.*
5. *Nearly all parents were very satisfied with Parent Training and particularly with the support and encouragement they received from other parents in the group.*
6. *Most parents understood the program's main message about positive parenting.*
7. *Parents were positive about the role of the group leaders, but more skeptical about some of the teaching methods used, particularly the use of video clips and role play.*
8. *Parents varied considerably in their ability to consistently and effectively use the new methods they were taught.*
9. *Some parents did not report improvement in their child's behavior after Parent Training.*
10. *Parents varied considerably in their views about the future.*
11. *Many parents wanted some form of follow-up help after parent-training.*

12. *Webster-Stratton Parent Training is a beneficial form of help for many parents of young children affected by severe behavior problems.*

Chapter 1 - Introduction

In this study we present the results of a research project designed to gain insight into the views and experiences of parents of children with severe behavioral problems, who have participated in "The Incredible Years" program in Trondheim. This was an innovatory program, designed to test interventions developed in the USA by Carolyn Webster-Stratton in a Norwegian child psychiatric setting. We have carried out a qualitative post-treatment study based on interviews with 19 sets of parents (single or couples) who participated in this program in Trondheim during the fall of 2001 or the spring of 2002. Its aim is to find out about parents' experiences raising a child with severe behavior problems from the time they first became aware of their child's problems until they were interviewed for our study, some 18 - 24 months after completing Parent Training. The study is, therefore, both a traditional user evaluation of parents' experience with Webster-Stratton Parent Training in Trondheim, and a broader retrospective study of parents' views on what it has been like for them and their family living with a child with severe behavior problems over time. The training program was targeted at children between the ages of 4 - 8 years of age, so by the time of our interviews the oldest children were 10 years old. Such studies are extremely unusual in Norwegian child psychiatry. In the present case the material we have collected, complements the findings from a clinical treatment trial study that was carried out as part of the Norwegian Webster-Stratton program. The 19 sets of parents we interviewed for this study in Trondheim were selected from the total of 127 families who received treatment during the treatment trial which took place in Trondheim and Tromsø from 2001 - 2003 (Larsson and Mørch, 2004).

The dissemination of new, more effective methods of helping children and young people with such problems has only started recently. In Norway this has been funded and supported by central government, and the programs have included research designed to establish whether the treatments and interventions provided, are viable and effective. In the Norwegian program that introduced Webster-Stratton's methods, it was from the start seen as important that parents should provide their views about the help they received. Their experiences and viewpoints were needed to provide a proper basis for assessing the value of the new methods, and whatever limitations these methods might prove to have. Parents might have ideas that could improve the treatment offered. At a more fundamental level, policy for child and adolescent mental health is being realigned. It is firmly stated that services for children must be provided in ways that are

acceptable for the families concerned, and nowadays it is generally accepted that parents should participate actively, and understand the thinking that is embodied in a service or treatment. They have a right to be involved and consulted, and it is believed that services will be improved when they are provided on a basis of partnership with parents.

This is the rationale for evaluation based on information provided by parents. We are interested in parents' experiences, including their views about help provided by various services and the help provided in a clinical setting, but our approach is rather broader than this. We have set out to view treatment of behavioral disturbances in the context of contemporary aims and ambitions for services to families. Services embody and communicate values and attitudes. In the last decade, we have increasingly seen that services for children and young people are being deliberately designed, with support from government, to embody principles and precepts derived from political and social preferences.

These *dirigiste* policies make new demands upon research. Evaluation must, in our view, be conducted in such a way that it can provide a critique of the service, rather than a verdict rendered in the terms imposed by the professional providers of the service, or the political and administrative owners of the service enterprise. This seems all the more imperative because government, in taking responsibility for service innovation, is tending toward an insistence upon "evidence based" provision, using objective criteria for service performance and scientific methods for evaluation. Empirically supported treatments, of which there are in reality still very few, seem likely to acquire pre-eminent status and can be effectively removed from the arena of debate and criticism. Their viability becomes a matter for experts, the few who are qualified to assess the evidence in the light of knowledge of programs and treatment. This is not really a desirable state of affairs: services ought to be debated and broadly evaluated, and not only by those who are committed to them for professional reasons. Programming on the scale the Norwegian government is committed to within children's services is, after all, a risky activity. Very high levels of investment might make it unlikely that some innovations could be reversed even if the "evidence" suggested that they were less than successful. Some programs have been introduced without much preliminary trial. And innovatory projects have to be defended against the perception that innovators, who also often evaluate their own programs, may be biased toward approaches that do not raise awkward or critical issues.

Helping the family

Behavioral difficulties among children and young people in Norway are nowadays pre-eminently a concern for child protection and child psychiatry. The centers and residential establishments which at one time played an important role in this field have disappeared, and educational services have not successfully focused on behavioral problems in school, apart from the problem of bullying, which has been an area for government-supported program activity in Norway. Behavioral problems affecting children, may lead to questions about the quality of care and supervision the family provides, and so lead to child protection concerns. Children approaching adolescence, or young people with severe problems, may need intervention from child protection because their behavior is effectively beyond control. Behavioral problems that are very severe, in effect represent a threat to the integrity of the family.

Child protection and child psychiatry are being increasingly drawn toward *family preservation* approaches, also in their work with behavioral problems. The term has been coined by Whittaker (1997), to denote services which aim to deal with children's problems, on the premise that the family is the best and preferred environment for the child, and for efforts to deal with difficulties the child may have. Complex strands of professional, social and political thinking are bound up this realignment. On the one hand it is widely recognized that invasive child protection, removal of children from home, and substitute care, often involve considerable risks. The impact on families is obviously very great, and there are moral and economic costs that many see as more or less unacceptable. Children in child protection often do not benefit much from the care provided: many outcomes are far from good. It is suggested that proper attention and support from families with serious problems and poor child care, can often retrieve the situation before families are broken up, and promote at least tolerable conditions for many children. There is also a belief that struggling families deserve quality support. Parents need to be empowered. In child psychiatry there is a trend toward approaches that involve parents more, and increasing recognition that children's mental health problems impose a severe burden on families, who are entitled to be helped on their own terms, instead of being stigmatized by the presumption that they provide poor care for the child.

Health service professionals and social workers want to do a good job, and they yearn for effective interventions. But interest in the new methods cannot altogether offset the recognition that family preservation has its ambiguities and dilemmas. These are partly

bound up with the difficulty of changing prevailing practices so that new methods can be applied properly, with due fidelity to their specific content and with adequate infrastructure, preparation and monitoring. Resources may not be available to do the job, or (as is often argued) the real issue may be one of prevailing attitudes and mentality. Some assert that the discipline required by modern programmed or manual-based methods is difficult to develop. On the one hand, the professions have had a culture of more or less individual choice of methods, so that loyalty to a structured program seems artificial and alien. On the other hand, employers and administrators of services may have reservations about working methods that require a good deal of investment of time and effort to become operative (because of training requirements, for example). Or services may be regulated and bureaucratized to such an extent that there is not enough room for innovation. There is also some evidence that community service personnel, even though they acquire competence at a level that would support use of programmed methods, do not often actually apply them. A self-perceived lack of professional authority and awareness of organizational constraints seem to play a part in this.

But as we see it, these constraints are not the most important problem raised by the new interventions. Family preservation services embody an important change in thinking about services for children and young people. They more or less deliberately set out to enhance individual and family responsibility. The traditional attitude to the family in the welfare state has perhaps been a doctrine of non-interference, though extensive supports have been available for families with certain types of need. Child protection and child psychiatry, however, are now offering help to *many more* families. Parents in difficulty are seen as having the right to appropriate services, and the right to participate in decisions about their children.

But this expansion of services also reflects the notion that parents have a duty to participate and to contribute actively to the efforts the services make. Parents may be expected to function as de facto coordinators of help provided by various agencies (Tronvoll, 1999), or may be encouraged to use services that require considerable expenditure of their own commitment, time and effort. Some services explicitly require changes in the family's internal organization and a willingness to change attitudes and child-rearing practices. Areas of family life that traditionally have been private and intimate are opened up. Parents are enlisted, not only to facilitate service delivery and invest their own time, but also to give professionals access to areas of family life that are held to be important for the management or treatment of children's difficulties. It is

in a sense axiomatic that parents are motivated to help their children and bear their part of the burden of work that the service requires. A child is not to be seen as a problem, but rather as member of a family with a problem, who must participate and play a role in the helping system. The family and not the child “own” the problem.

One of the features of this realignment is a determination to reduce the stigma that can attach to families’ use of services such as child protection and child and adolescent psychiatric services. Stigmatization of vulnerable and deprived children and young people is a problem in many countries. Colton et al. (1997) provide international comparative data to document this. The greater the difficulties and disadvantages children and young people confront, the greater the risk of them being stigmatized. Services are often provided in ways which unfortunately increase the burden. Since education, health and social services are identifying more and more young people who need help, and since Norwegian policies have resulted in a rapid growth in the numbers of children and young people who are categorized as having special needs, the risk of stigmatization is very real. Critics (Wyn and White, 1997) have suggested that the growth in the numbers of children who are defined as having special needs exposes those concerned to the risk of marginalization.

The unintended stigmatizing effect of specialized service provision can outweigh the benefits such services provide. Child psychiatry has always itself evinced a good deal of uneasiness about this. A very strong emphasis has been placed on the voluntary nature of parents’ involvement with psychiatric services and the absolute nature of confidentiality. Present policy aims at a considerable enlargement of the numbers of children and young people receiving help from child psychiatry, in effect an increase of about 120% over an eight year period. Child protection services provided for children living at home have increased more than threefold since the mid-1990’s. Services have to be made more accessible and barriers, including constraints on cooperation between child psychiatry and other agencies, reduced or eliminated. But above all, government would like to see a stronger commitment to involving parents as active partners in treatment and preventive work. It is believed that this will combat stigmatization and encourage parents and other adults to seek help for children in difficulties.

Parenting and partnership

These very pronounced changes in assumptions underlying service provision, which of course have emerged gradually, over the last fifteen years or so, are not really controversial. There is an overriding context, in the sense that developed societies in Europe, North America and Australasia have all, in recent decades, built up increasingly complex services to deal with problems of child and adolescent development, anchored in a broad dissemination of ideas based on theory and research in developmental psychology, education, and child psychiatry. There is a general perception that some developmental and mental health problems, at least, are on the increase. This has led to greater interest in parenting and early development, and preventive programs and efforts to devise effective early interventions. And as we have indicated, services are provided for many more families.

Changes in the politics of services have to some extent been paralleled by changes in the way agencies and professionals think about service delivery for families, though it is hard to be sure about the extent to which services have adopted new approaches. Certainly the overt basis of professional thinking has altered. A useful essay by Madsen (2001) summarizes one aspect of this. Clients and patients are increasingly seen as having the right to participate fully in partnership with professionals, and as having the right to define what their problem is. The basis of this is the notion that those who have problems are the "owners" of these problems, and that the ethics of professional conduct make it impermissible for others (including professionals) to abrogate an individual's rights in this respect. In a sense the direction of thinking in many professions has become client-centered in the sense that this term has been applied in social work for many decades. The modern position is also quite clearly that parents in principle have these rights in respect of their children. The *Strategic Plan for Child and Adolescent Mental Health: Together for Mental Health* issued by the Norwegian health department in cooperation with six other government departments in 2003, asserts that parents have the right to an explanation of their child's difficulties and the treatment considered appropriate, that is comprehensible to them in their own terms (Norwegian Department of Health, 2003). And they have the right to participate in all the decisions that are made during assessment and in respect of treatment.

These changes are often loosely referred to as client or patient "empowerment". The term has its origins in social work, and originally had perhaps a more overtly political connotation: clients were to be provided with help so that they could directly influence political decisions that affected their lives, for example decisions in the local commu-

nity that affected the quality of their lives or the provision of local services (e.g. Solomon, 1976). Empowerment in this community organization form has not proved very popular in Norway (Marthinsen 2003). Empowerment is nowadays not usually thought of in this way, but is rather used to denote the obligation to enable clients so that they can influence decisions that affect their interests in the delivery and design of the services they themselves are provided with. And the concept of empowerment has also been extended to indicate the desirability of services that provide people with a real basis for working on and solving their own problems.

"Empowerment" in this sense is a delicate problem for child protection and child psychiatry. Both services have a long tradition of seeing some children's problems as a consequence of their relationship with their parents, and of family dysfunction. Child protection and child psychiatry in their very nature are obliged to explore the issue. This is legitimized in the *welfare science* knowledge base child protection and child psychiatry have developed, in which particular types of deprivation or dysfunction are associated with harm for children. Child protection and child psychiatry in Norway have shared this knowledge base, with child psychiatry usually in a pre-eminent position: a number of studies of inter-professional cooperation in Norway have shown that those who work in child protection in particular see child psychiatry as a source of professional insight and authority.

Welfare science has been criticized by right-wing thinkers, especially in Britain and the USA, precisely because of claims or perceptions that it establishes an unassailable professional position that tends to render clients dependent on experts, and also tends to invalidate clients' own view of their problems. A related issue is that it can be difficult for professionals to avoid drawing moral or moralistic conclusions, when issues relating to contested issues such as parenting are involved. The actual basis of the judgments made in community services has been shown in some settings to be more closely allied to ordinary community social mores, then to scientific or professional knowledge as such. Child psychiatry has been very rarely exposed to sociological enquiry, but it perhaps should not be taken as read that it always has managed to avoid a covert moralistic approach to dysfunctional parenting.

Practices which give parents better access to information and to decision making have become very widespread in Norwegian children's services. Children with very severe problems and special needs are often followed up by special inter-agency groups, and parents very often attend meetings in these groups. Child psychiatry has also given parents access to decision-making and access to information. In fact, practices of this

kind have been common in child psychiatry (though by no means universal) for at least two decades.

However, there is very little research which tells us much about how parents perceive services for children and young people. In respect of child protection, the most important recent Norwegian study is that by Marthinsen (2003). He applies the double-informant approach common in social work research in the 1970's and 1980's to child protection. Both clients (parents) and social workers provide their views about the conduct of particular child protection cases over a lengthy period of time. Marthinsen's work is especially interesting because it focuses clearly on the situation of children in families where there is a lack of resources (that is resources in the broad sense, such as occupational status, relations with community, network and kin, income, and poor everyday functioning). He explores the delicate balance between willingness to co-operate, and tactically motivated concealment which parents of children deemed to be at risk, in families with poor standards of care, often tried to maintain. Theoretically, his contribution is interesting, since it provides a stimulating account of how client status reflects a lack of social capital, and how social workers make efforts to ameliorate this for the children concerned.

Research that can tell us about parent's perceptions is even rarer in Norwegian child psychiatry. A recent pilot study, in which parents of child psychiatric patients in a clinic in a local center were interviewed, does provide some interesting findings (Heian, 2004). Most parents described a lengthy process in which concern about their child's difficulties had led to a degree of frustration. Community services could not provide satisfactory conclusions about the nature of the problems, or their cause. Parents found that child psychiatry was able to give a name for and an explanation of children's difficulties, and this was a considerable relief. Parents also generally felt that they were very well treated by child psychiatric personnel. There are some signs that they appreciated being asked to attend meetings to review children's progress and treatment, but the main benefit of this, as they saw it, was the information that this provided. None felt qualified to make much contribution to the decisions made. The exceptions to this benevolent parental view of child psychiatry were a few parents who had been referred by child protection, who were suspicious and felt that they were being persecuted. Even these parents seemed to appreciate the concern and interest shown by child psychiatric staff, but they had questions about whether they should have to attend at the clinic at all. This finding can be interpreted in various ways, but it seems that the element of coercion which is often present (or perceived to be present) when child protection clients are referred to child psychiatry, does lead to reservations on the part of the parents concerned. On the whole, these findings seem to suggest that

parents may not be as reserved about the expert position enjoyed by psychiatric staff, as the authors of the Strategic Plan (The Strategic Plan for Child and Adolescent Mental Health, Helsedepartementet 2003) seem to have thought. They experience profound uncertainty and distress when their children have apparently intractable problems, and they want answers, which psychiatry on the whole seems able to provide. It would not be unreasonable to suggest that the whole field of child psychiatry - parent relations requires research, and at present seems to be dominated by empirically unsupported assertions.

This lack of knowledge seems to be at the core of the problem we encounter in changing services for parents who have to confront the difficulties that are due to their children's mental health problems. Norwegian government policy can reasonably be interpreted as an effort to avoid stigmatizing effects of child protection and mental health provision. But government's view of the problem is an ideological assertion more than anything else. A recent survey by Mitchell (2004) in respect of the state of affairs in Australia, could quite reasonably serve as a description of the state of affairs in Norway too. She concludes that there has been little development of thinking about non-medical service contributions in the child mental health field. A consequence is that scarce psychiatric facilities and treatment are rationed out among children, who must "qualify" for help. Government sees these issues most often in global and organizational terms, and argues on a basis of perceptions of services that may convey some of the reality, but which also have a mythical, prejudicial aspect. Psychiatric services in themselves are unfortunately narrowly focused: there is little awareness of community service contributions, support or follow-up, and we lack conceptual frameworks to deal with these issues. So although community service personnel may want to provide a broader range of services, the base for this could hardly be said to exist. Mental health provision for children and young people does not only require effective methods and an open, non-prejudicial relationship between professionals and families. It also requires a much broader community service base.

So we have an ideological commitment to work towards services and methods that embody partnership between parents and professional helpers, but at best an only incomplete conceptual and organizational basis for services that can realize this. At least part of the difficulty is conceptual. It is hard to work out what are the central aims and operant criteria for services that are to have an empowering effect. A good academic text which approaches some of these issues is a collection of articles edited by Tronvoll and Marthinsen (2000). But here too there seems to be rather more theorizing than empirical material dealing with client expectations and experiences of provision.

The new family services (Parent Management Training, Multi-Systemic Therapy, Families First, and family counseling and mobilizing approaches of various kinds) that have been introduced are at best only partially documented insofar as user evaluations are concerned. On the whole, it seems that users often appreciate efforts to get them more involved, but perhaps the more important question is whether this type of service gives parents a better platform for their own efforts to deal with problems. It is especially the medium- and long-term benefits in this respect, which are of interest.

Webster-Stratton Parent Training: A Critical Test of the Family Preservation Model?

Our starting point in this research was that the Webster-Stratton Parent Training program is a central example of a family preservation effort, conceived with the express intention of meeting families with needs and parents who are exposed to stress, disorganization and subjective distress. The program sets out to meet parents on their own terms, by allowing them to participate in developing ideas and approaches to managing the affected child, and by maintaining a constant focus on everyday situations, conflicts and problems. It embodies principles that are widely deployed in modern treatments for behaviorally disturbed children, and in addition exhibits a number of features that are generic to family preservation approaches.

It is based on the premise that the most effective way to help the child is to deal with his or her behavioral problems in the home, by means of appropriate management on the part of parents. The program does not involve any compromise about this: there is no follow-up or ongoing support once parent training has ended. Parents are expected to apply what they have learned in the group sessions. The child's behavior is seen as a problem for the whole family, which the family must deal with. Parents must effect changes in their child's behavior: success depends on their own efforts.

Parent Training requires a considerable commitment of time and effort on the part of parents. It is based on their willingness to alter various aspects of their relationship with a troubled child, and to change they way they function in their family setting. The training itself requires openness. They must discuss their parental role and behavior, their frustrations and emotional responses to the child's behavior, with other adults. This can scarcely be easy; many parents in their situation suffer from feelings of guilt. They often feel that the child's behavior is due to their own failure as parents.

Parent Training requires non-judgmental, skilful and consistent leadership from the professional group leaders, and probably should be regarded as a considerable therapeutic challenge. The factors that offset this threshold of complexity and difficulty, seen from a therapeutic standpoint, are that training procedures have been carefully thought out, that the treatment is manual-based, that rigorous standards are enforced in connection with training, and that support and supervision are provided. All these factors are thought likely to be favorable for outcome, but at the same time they represent costs. Agencies that want to acquire competence in these methods have to invest in training, and once the methods are in place they have to be adhered to.

It is probably not an exaggeration to say that parent training in the Webster-Stratton program in Norway represents a critical test of whether family preservation strategies can work, since so many factors that affect the quality of the service provided were favorable in the program. There were no serious constraints as far as resources go, and the innovators were allowed adequate time for planning, implementation and training. The treatment was known to be highly effective when judged by the standards that are applied in evidence-based method development and evaluation. Webster-Stratton's own catalogue of treatment evaluations has had an emphasis on longitudinal design. Follow-up studies and long-term follow-up studies (after ten years) have been carried out. These indicate that treatment effects are well maintained over time. Apart from Webster-Stratton's own qualitative study (Webster-Stratton and Spitzer, 1996), however, there is very little detailed evidence available to assess the impact of the treatment upon parents and families.

A service or treatment that sets out to enable parents and give them a realizable aim of contributing significantly to dealing with their child's problem, must clearly satisfy certain requirements. In the list of such requirements that follows, the issues that our study can to some extent throw light upon, have been italicized:

1. It should be clear which children can benefit, and the criteria for deciding who can be helped should be clear, unambiguous, and possible to apply in practice.
2. The service or treatment should be accessible (treatments for children require, obviously, that help is accessible for parents).
3. Service or treatment should be systematized and organized in such a way that it can be learned and reproduced accurately, and applied in normal conditions.
4. It should have elements that appeal to parents and that are motivating for them.
5. It should give parents an understanding of their child's difficulties and of their own role and choices in respect of these.

6. It should provide specific solutions to the real, everyday problems that children and parents encounter.
7. The approach should contribute to a strong and close relationship between child and parent.
8. It should be comprehensible seen from parents' standpoint.
9. It should not involve techniques or approaches that are unrealistic or too demanding for parents.
10. The approach chosen should give parents a permanent platform for dealing with the child's difficulty and managing the problems. This involves a range of issues, such as technique and strategy in the approach to the affected child, as well as motivation and self-care for the parents.
11. There should be a clear, documented, long-term and reliable effect.
12. The effect of program participation should include de-stigmatization and a reduction of subjective burdens, such as stress, feelings of guilt and inadequacy, and isolation, which are usually present when parents have to deal with serious problems affecting their child.

This is probably only a minimal list of requirements, but it indicates the scope of the evaluation and discussion that is required to establish the validity and feasibility of family preservation services. Relatively few of these issues can be approached using the methods that are usually deployed in treatment evaluations in child psychiatry, and the standardized user evaluation questionnaires that are often used, cannot throw much light on them either. It is hoped that this study which asks parents to describe in detail their experiences raising a child with severe behavior problems, and about their views on the help they have received both from community services and from child psychiatry through the Webster-Stratton Parent Training program will help to shed some light on the effectiveness of this type of family preservation program.

Helping children with severe behavior problems

Diagnostic categories

Webster-Stratton's programs are designed to help children with very severe behavioral difficulties. The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) classification system includes two such serious behavioral disorders which can affect children (American Psychiatric Association, 1994). *Oppositional de-*

fiant disorder (ODD) has the following symptoms, which have to be present for at least six months for a diagnosis to be made:

The child often:

- Actively defies or refuses to comply with parent (adult) requests and argues
- Loses her/his temper, easily irritated, becomes angry
- Yells, screams
- Is spiteful and vindictive
- Blames others for his/her mistakes.

Conduct disorder (CD) is characterized by the following symptoms:

- The child is aggressive toward people and animals, bullies, is involved in physical fights and shows cruelty
- Destroys property, may set fires
- Is deceitful, steals
- Commits serious violations of rules (stays out nights, runs away, truancy).

These symptoms must have persisted for the last 12 months. In effect children who fulfill the diagnostic criteria described here are exceptionally difficult to manage or be with. Conduct disorder will be less frequent among children under the age of eight or nine: most behaviorally disturbed children of preschool or early primary school age will have ODD symptoms. Whatever the diagnosis, these are exceptionally troubled and unhappy children.

Prevalence estimates

Estimates of the prevalence of conduct problems have varied widely, and there has been a lack of research in many countries. Internationally, we see estimates based on research that vary between 5 to 10 percent of children and young people affected with behavior problems, where about half of these have severe behavior problems (Kazdin, 1997). Research being conducted at present suggests that prevalence rates may be lower in Norway (Lurie and Clifford, unpublished). This is consistent with previous Scandinavian standardizations of American assessment instruments (e.g. Reedtz and Bertelsen, 2001; Larsson and Frisk, 1999).

Impact on children and their families

When dealing with behavioral problems among small children, we meet unhappy and confused children *and* adults. Few burdens are as heavy as those parents must bear

when a child has an apparently intractable problem, and this is certainly so in the case of severe behavioral disturbances, which can lead to desperation, anger, demoralization and disruption for the families concerned. Untreated behavioral disturbance among children implies a poor prognosis both for the children involved, and for their families.

Awareness of the impact such problems have, both for the children concerned and for their families, has grown over the years. Severely affected children are apparently locked into a cycle of deteriorating behavior and ineffective management on the part of adults, whether these are parents or teachers, or social and health service personnel. They run a risk of developing anti-social behavior patterns as adolescence approaches, often necessitating intervention from child and youth protection.

Previous research indicates that families of children with behavior problems experience high rates of major and minor life stressors (e.g. Forgatch et al., 1988), marital stress (e.g. Schaughency and Lahey, 1985), and social isolation and lack of social support (Dumas and Wahler, 1985). One of the few previous qualitative studies of the impact on the family of living with a child with conduct problems found that the child's behavior introduces significant stresses into his family system, that these stresses have a cumulative effect on parents, and that the child's behavior also has consequences for siblings, other relatives, and the family's relationships with the community (Webster-Stratton and Spitzer, 1996).

Early intervention

Early intervention is recommended because research in the last twenty years has established that behavioral disorders *can* be detected at an early age (from around four years of age) and because these problems, once they become evident, are relatively stable. They are likely to persist unless some form of effective treatment is provided. It has been shown that early onset in itself tends to predict more severe, long-lasting problems and a poorer outcome, with a substantial risk of anti-social behavior in later childhood and adolescence, and in adult life. The severity and scope of symptoms at an early age are associated with outcome; the more problems early on, the poorer the outcome. Co-morbidity of ODD and Attention Deficit Hyperactive Disorder (ADHD) gives a particularly unfavorable prognosis, and these two disorders frequently occur together. If problems are manifest in more than one setting, for example in the home and in day care/school, the prognosis is also unfavorable (Campbell, 1995).

Positive Parenting: Webster-Stratton treatment program

One type of early intervention which has shown it self to be effective in the United States, in helping families of children with severe behavior problems, is the Webster-Stratton Parent Training program, "*The Incredible Years"*. Webster-Stratton's methods belong to a "family" of related treatments based on parent training, developed in the USA in the 1980's (Forehand and McMahon, 1981; Webster-Stratton, 1981; Eyberg and Robinson, 1982). These treatments have a number of elements in common. *"The Incredible Years"* is a treatment program for children with severe behavioral disturbances, targeted at children in the 4 - 8 age range. It was developed by Carolyn Webster-Stratton at the University of Washington, Seattle, in the USA (Webster-Stratton, 1982, 1984, 1990a, 1990b). It has been widely regarded as one of the best-documented and successful intervention approaches not only in the field of behavioral problems, but in clinical child psychology and child psychiatry in general.

The program consists of a number of different manual-based treatment packages, all of which are related, having basic principles in common. In addition to treatment based on parent groups, known as the Basic Program, there is an Advanced Program for parents which involves a larger number of sessions, allowing a focus on the parents' relationship and functioning. A treatment program for groups of children - Dinosaur School - has been developed in two versions, one clinic-based and the other adapted for use in kindergarten or school. These children's programs set out to improve social skills, which behaviorally disturbed children often have not acquired, and need very much. A Classroom Management Program has also been developed to assist teachers and preschool staff; in essential respects this is an adaptation of the Basic Program.

Most of these treatments have been tested extensively at the Parenting Clinic at the University of Washington, Seattle, using randomized group designs.[1] Not least because of the stringent designs applied, Webster-Stratton's methods have been regarded as fulfilling the strictest criteria for evidence-based treatments. Webster-Stratton has carried out no fewer than nine controlled treatment outcome studies and three preventive studies. These include comparisons of the Basic Program with waiting list controls, with the Advanced (Parent Training) Program, and with a combination of Basic Program and Dinosaur School. All these studies are controlled trials with one-year follow-up.

[1] The partial exception is the Classroom Management Program, which at the time of writing has only been evaluated in one study.

In addition, the Basic Program has been evaluated in a few replication studies in Canada (Taylor et al., 1998), in the United Kingdom (Scott et al., 2001), and most recently here in Norway (Larsson and Mørch, 2004). Available research (see Beauchaine, Webster-Stratton and Reid, 2004) suggests that the Basic Program, which we will call *Parent Training*, is the most effective of these treatments, and the most robust since its effects are least moderated by a variety of unfavorable factors. All parents interviewed for our study completed the 12 week Parent Training or Basic Program, and children in half of the families also participated in a clinic-based Dinosaur School program.

The Norwegian treatment trial

Introduction and trial of these methods in Norway was recommended in 1998 by a committee appointed by the Norwegian Research Council, in response to a government initiative (NRF rapport, 1998). Parent Management Training (PMT) and Multi-Systemic Therapy (MST) were also recommended, but for implementation. The thinking seems to have been that the feasibility of the *Incredible Years* in our settings might be in question, so that a carefully organized trial was required. A randomized treatment trial (a replication of one of Webster-Stratton's studies) was organized in Trondheim and Tromsø. We will not describe this trial in any great detail in this report, however some comments about the treatment offered, and the setting, are required.

Parent Training and Dinosaur School (which was also provided in the treatment trial) were innovative in the context of child psychiatry in Norway. This is partly a matter of methods. Group work with parents is not altogether unknown in child psychiatric clinics, but it is not used frequently. Manual-based treatments with a strict, programmed sequential order have been very unusual. Group therapy for small children, as in Dinosaur School) is also very unusual.

Basic principles

The core of the Webster-Stratton approach is contained in the expression "positive parenting". It is based on the postulate that children *learn* behavior, and behaviorally disturbed children must "unlearn" behaviors that are undesirable. They will not usually "grow" out of their difficulties, because their behavior unleashes negative responses and sanctions, which only serve to reinforce the very behavior adults want to prevent. Positive reinforcement is required, and this has to be applied systematically and consistently. The obvious agents to accomplish this are parents, who are closest to the child, have most to gain from an alternative approach, are likely to be highly motivated, and who suffer considerable distress on account of the child's behavior. Behav-

iorally disturbed children often have extremely poor relationships with their parents, who have usually become exhausted and frustrated. Therefore it is important to teach parents how to relate to their child, in an age-appropriate way. It is important to avoid harsh and negative parenting and physical punishments. All of these merely intensify a cycle of negative interaction.

So parents also have to learn a different approach, and unlearn inappropriate parenting strategies. It is both normal and acceptable in our culture, that adults apply sanctions to undesirable behavior on the part of children. This is an essential feature of socialization, and is held to work well enough for most children. Moreover, the content of this sanctioning and the way it is carried out is usually regarded as the parents' prerogative. Physical punishments are unacceptable according to Norwegian law and are also disapproved of, but apart from this, sanctioning and control of children's behavior is regarded as a private matter. Behaviorally disturbed children, however, do not respond to normal, accepted approaches to sanctioning of behavior. Genetic and other factors, some of them related to styles of parenting or inappropriate management on the part of adults, require that a different regime be adopted.

It has been shown that many parents can acquire these skills without expensive interventions, in the sense that self-administered programs can lead to a new approach on the part of the parents and improved child behavior. But *parent training* by specially trained helpers is seen as the best approach, being most supportive and providing a positive atmosphere for learning. Webster-Stratton's manual-based parent training can be thought of as a form of group psychotherapy, or a form of tuition, depending on the vantage point we adopt. But training seems to be the most suitable term since the focus is upon acquisition of skills to apply in everyday, practical situations.

Content and Structure of Parent Training

The Basic Program can perhaps best be described as a composite of different methods and themes. This is quite explicit in the sense that the structure of the program is sequential, with the early sessions devoted to helping parents understand how to strengthen their relationship with their child, and understand age-appropriate ways of relating to children, and not least what are age-appropriate expectations. The program then moves on to deal with practical and everyday issues - what rules should be enforced, and what routines can be established - before dealing with methods parents can use to avoid reinforcing undesirable behavior. Treatment consists of two-hour weekly group sessions, in all lasting 12 - 14 weeks. Some of the devices taught are counter-intuitive, such as the necessity of ignoring annoying and irritating behaviors. Or cul-

turally somewhat alien, such as the extensive use of rewards for children. An understanding of behavioral analysis principles on the part of group leaders is necessary: this is dealt with in a preliminary workshop before trainees study the manual, prepare sessions, and begin their work with groups of parents.

The groups consist of 12 - 14 parents (some other significant adults may be drawn in when this is considered appropriate) and sessions must be conducted so as to involve all participants. Group leaders (there are two in each group) have somewhat different roles. They must take care to respond to all the initiatives and questions that arise, as immediately as possible. A group session must not end with unresolved questions. The main devices the sessions are based on are video vignettes, which are used to introduce topics and illustrate points, and role play, in which group leaders are expected to take the lead. All sessions are videotaped and used in debriefing supervision afterwards. This is an important aid to supervision and program fidelity, and is especially important in training. One group session will require about 12 hours' preparation and debriefing for group leaders in the training phase. It will be evident that group leaders need to develop considerable group work skills during their training.

On the whole, Webster-Stratton's policy has been that it is better for group leaders to specialize in one or other of the variety of treatment programs, at least until considerable experience has been gained. Training, as elsewhere in clinical practice, is largely practical, and it is based on *working with parents.* There is relatively little theoretical or classroom training divorced from actual preparation for groups or de-briefing and supervision. Few of the staff recruited to the project had much experience of group work, and none had done group work so highly structured as Webster-Stratton's treatment prescribes.

There are a number of features of the treatment that deserve special comment since they may have had some impact on the way parents perceived the sessions and indeed the treatment as a whole:

1. Group sessions are manual-based: each session of two hours in the sequence must deal with particular topics. There must be no "run-over" between sessions. Group leaders must lead the group through the video vignettes that are specific to each session. Despite this structuring, it is imperative that sessions build on initiatives and contributions from the parents themselves. Conclusions in the form of principles and rules should be emphasized, but as far as is possible these should be identified with conclusions and insights parents themselves have expressed. This is important because it is regarded as all-important that parents identify closely with the content of the training. Discussion and consid-

eration of practical ways of helping children must be related to parents' own experience and problems. These guidelines are easy to state, but no doubt difficult to practice.

2. The group sessions constitute the whole of the treatment. As a rule, supplementary individual counseling is not provided, though the clinic might respond to an exceptional situation. The intention here too is to get parents to identify with the group, see that other parents have the same kind of difficulties as the ones they encounter, and see the "lessons" learnt in the group as their own "property". Other devices and strategies underline the socially rewarding aspect of belonging to the group. Sessions are arranged at times that are convenient for parents (after normal working hours). Personnel are provided to look after children if parents are unable to make their own arrangements. Coffee and tea and light meals are provided, and parents can have travel expenses reimbursed. All effort is devoted to ensuring that parents can attend each session, and non-attendance is always followed up. Parents are contacted and offers of assistance made if practical difficulties have arisen. All this underlines the message that each parent is important and valued as a member of the group. No structured follow-up after the completed course of sessions is provided.

3. Parents have to engage in some activities that might be unfamiliar. For example they have to engage in role play, and it is expected that they will attempt to practice the principles developed in group sessions, at home. These "homework" tasks are followed up in the next session.

4. An explicit aim is that sessions should be enjoyable. Laughter and humor are seen as important, even though the sessions deal with serious and painful issues. A light tone reduces the threshold for learning and identifying with the group and the group process. Hesitant parents will be encouraged and reassured much more easily when the general atmosphere is lightened. This aspect of group management is also part of the group leaders' responsibility.

The setting and research requirements

The clinical settings that were organized to offer Webster-Stratton treatment were quite untypical of child psychiatry in several respects. Most of the group leaders were specially recruited from settings outside child psychiatry. Only a few had received the relatively lengthy training that is normally required for those who must qualify to work in Norwegian child psychiatric clinics.

The trial teams were also organized as separate enclaves within their clinics, and especially so in Trondheim, where the majority of families involved in the trial live, and where the trial was conducted in a special research clinic set up for the purpose. Staff received specialized training, quite distinct from the usual training given in child psy-

chiatry. This team composition to a great extent served to isolate the two Webster-Stratton treatment teams from the child psychiatry settings where they were located. Insofar as the host clinics could exert an influence, this would be transmitted to the treatment teams by their leaders, who had long experience of child psychiatry, or indirectly by means of procedures and structures imposed by the host clinics. It seems likely that the trial personnel were most strongly influenced by the training and supervision which they received in the project, as was indeed intended: recruitment of staff without child psychiatric experience was a means to ensure that special training had as much impact as possible. Prevailing expectations relating to child psychiatry, on the part of parents, might still operate of course, since they probably would not fully appreciate that the Webster-Stratton service in effect had been set up in a special "customized" setting.

Treatment not only had an innovative design and context, but it also took place in a highly specialized *research* setting. Children and families were assessed before admission to the treatment, but this assessment in most cases did not amount to a full diagnostic assessment like that which is universal in normal practice in child psychiatry. A need to control the clinical setting in order to facilitate research procedures and ensure fidelity, led to procedures which differed in some important respects from that which would be usual in a child psychiatric clinic. Parents encountered this when they entered the program, the more so of course, because the already sequentially ordered treatment was complemented by quite elaborate measurement and assessment procedures. Parents were, to put it simply, placed in a situation that was initially more demanding than what would have been the case in a conventional approach in child psychiatric work with consultation and counseling. They had to fill in a large number of questionnaires and test instruments, undergo interviews dealing with many issues, some of them sensitive, and attend the clinic with the child so that observation-based tests could take place. Parents had to accept the uncertainty attendant upon a randomized waiting-list design, and a minority had to wait for some months before treatment could start, because their child was assigned to the waiting list control group.

Benefit for children and their parents is the justification for evidence-based methods. For the parents in the project, the reality of evidence-based treatment was in the first instance a burden in the form of assessment procedures that had to be completed before treatment could begin. Some parents had reservations about this and a few elected not to enter the program for this reason. A few did not want to complete follow-up assessments after treatment. Referral procedures too would tend to convey to parents that they were entering a "special" innovative program. Information about the program in local and national media would have the same effect.

Research methods

Why choose a qualitative approach?

As previously discussed, multiple quantitative studies have been conducted in the United States and replicated in other countries including the United Kingdom, Canada, and now Norway, which clearly demonstrate, that Webster-Stratton Parent Training is a highly successful intervention which improves both child behavior and parenting practices. 60 - 70% of the children whose parents complete training in the United States show much improved behavior after treatment, and these improvements are maintained at follow up. Replications have attained results that are highly similar. In the Norwegian replication study in which our interviewees took part, the average behavior scores for the treated groups of children were within the normal range of variation after treatment. All the children had a diagnosis of behavioral disorder before treatment; and three-quarters of them were outside the diagnostic range after treatment. Parents reported a reduction of stress levels and fewer harsh or inconsistent parenting practices. There were also considerable problem reductions on measures of internalizing problems, and for the large number of children in the study who also were diagnosed as having Attention Deficit Hyperactive Disorder (ADHD) (e.g. Webster-Stratton et al., 1982; Taylor et al., 1998; Scott et al., 2001, Larsson and Mørch, 2004).

The main limitation in the literature dealing with these methods (and in our view a limitation which was likely to be reproduced in the Norwegian treatment trial), is that the impact of treatment upon families, from their own perspective, is not particularly well understood. Quantitative studies can measure adult perceptions of changes in child behavior before and after treatment, but are not well-suited to find about parents' perceptions of what it is like undergoing parent training. Questionnaires can measure overall parent satisfaction with parent training, but are less able to go in depth into the training process itself to find out how the process works and which aspects of training are more or less successful, seen from the perspective of the participants. In depth qualitative interviews, such as those we employ in this study, are also much better suited for finding out about parents' retrospective experiences over a period of many years (the oldest children in the study were 10 at the time of our interviews) of what it has been like for them raising a child with behavior problems, and what consequences this has had for them, the child, and other family members. Qualitative interviews are also appropriate for gathering information about how things have gone with the child and the parents after treatment, and how they view the future.

Webster-Stratton and colleagues have conducted three qualitative research studies which were designed to supplement the findings of their numerous quantitative clinical research studies. These studies focused on parents' perspectives at three points in time: prior to intervention, during the therapy process, and 2 - 3 years after intervention (Webster-Stratton and Spitzer, 1996). These studies produced useful information about parents' perceptions of life with a child with behavior problems before, during, and after parent training, and have been a useful frame of reference for our study which addresses similar issues. There are also some differences. Webster-Stratton's studies focused more on the different phases of the treatment process and parents' changing perceptions at different stages of treatment. Their follow-up study covers a longer time frame (2 - 3 years as opposed to 18 - 24 months in our study) and they were particularly interested in the persistence of treatment effects of various kinds. Our study was designed to be somewhat broader in scope, with a greater emphasis on parents' experiences raising a child with behavior problems before starting Parent Training, and with more focus on what aspects of Parent Training parents found to be most and least useful.[2]

It is important to find out how Norwegian parents experienced Parent Training and raising a child with behavior problems. Replicating the clinical treatment trial in Norway, without interviewing parents in depth about their perceptions of the treatment process, and their experiences before and after Parent Training would leave a number of important unanswered questions. There are very few qualitative research studies in Norwegian child psychiatry, which has derived its research ideals from medicine and clinical psychology. The usual emphasis is upon measurement of theoretically established and relevant individual characteristics, and in treatment research within a framework of pre-post design. Standardized and validated measurements and instrumentation are the ideal in data collection, and clinical research (research designed and carried out in conjunction with treatment, in the clinic) has high status. There is a very firm belief that clinicians are best qualified to carry out research that is relevant to treatment and clinical practice in general.

2 Originally we had intended to carry out an in-depth study of some families whose behaviorally disturbed children had not received specialist treatment, but it proved difficult to recruit enough of these parents. We, instead, supplemented the user evaluation of the treatment, with questions relating to families' experience before they entered the program, and their situation after treatment (that is, around one-and-a-half years after treatment ended). We wanted to see how the challenges parents face, develop after they have received help. And we were interested in the way in which parents perceive their situation at that stage, and judge the extent of the support and help they have received before, during and after treatment.

This study broke with all of these conventions and rules. We were very interested in how parents perceived their situation before, during and after treatment, but we were wary of making a priori assumptions about this. A main motivation for a qualitative approach was to avoid the questions that parents answered many times in the successive assessment phases necessitated by the experimental treatment trial design, with its initial screening, extensive intake interview, and even more extensive assessment pre-treatment, post treatment, and at one-year follow-up, all based on highly structured questionnaires and interviews. We wanted to get some of the most researched parents in the history of Norwegian child psychiatry to use their own words.

Design

This is a qualitative study based on in-depth interviews with 19 sets of parents (couples or single parents) who have raised a child with serious behavior problems. The parents were selected from the 127 families who received Webster-Stratton Parent Training, as part of a clinical treatment trial conducted by child psychiatry university clinics in Trondheim and Tromsø during the period September 2001 - June 2003. The program is targeted at parents of children with serious behavior problems between the ages of 4 - 8 years. The parents participated in a 12-week Parent Training program in Trondheim fall 2001 or spring 2002. Children in half of these families took part in children's groups (Dinosaur school) aimed at improving their social interaction skills.

Characteristics of the children and parents in the study

For practical reasons, the 19 sets of parents selected for our interviews were chosen from among 54 families who had received treatment in Trondheim in the fall of 2001 or the spring of 2002 (out of the total of 127 families who received treatment in Trondheim or Tromsø during the whole clinical trial). These families had all completed their one year post-treatment assessments, and were, therefore, finished with their participation in the clinical trial. Three of the families were unwilling to participate, so selection was limited to the remaining 51 families.

The sample was selected strategically to ensure variation with respect to a few key characteristics, and was not intended to be statistically representative of the total treatment group. These were the age and gender of the child, the treatment type (parent training only or parent training plus dinosaur school for children), and mothers' perception of changes in the child's behavior before and after Parent Training (as measured by frequency of different types of problem behavior on the Eyberg Child Behavior Inventory (ECBI). Changes in the child's behavior were used as an alternative to

parent satisfaction ratings, because we knew that most parents had given the training a positive rating on a questionnaire completed at the one-year follow-up assessment (over 90% had rated the program as either good or very good).

The overview in tables 1 - 8 shows that we obtained an age range for treated children from age 6 - 10 at the time of interview, corresponding to about 4 - 8 at the start of treatment. The majority of children in our study were 6 years or older at the start of treatment, which was also the case for all the families receiving treatment. It was more difficult to recruit the youngest children for treatment. Children were divided equally between those who had attended Dinosaur School, and those who had not.

Table 1 Child's Age and Sex

	1993	1994	1995	1996	1997	Total
Boys	2	4	4	3	1	14
Girls	2	1	1	1	0	5
Total	4	5	5	4	1	19

Table 2 Treatment Type

Parent Training	Parent and Child	Total
10	9	19

Table 3 shows the changes in children's behavior as measured by ECBI (mother reports). This was the most important variable in the strategic sample, but sampling was complicated by the fact that some parents had not participated in follow-up assessment at the time the sample was drawn. Three of the families in our sample did not have pre and post treatment ECBI scores. These parents did subsequently participate, and the ECBI scores for their children proved to be poorer (i.e. more undesirable behaviors) than the average for treated children. So the sample proved to be somewhat more unrepresentative of the group of treated children as a whole. Our sampling biased the interviewed group in this direction anyway, and the children of parents who had not completed follow-up accentuated this bias. Parents of children showing little improvement in behavior after treatment are, therefore, somewhat overrepresented in our sample. This has to be taken into account in interpreting our material.

Table 3 Change in Child's Behavior Pre and Post (ECBI)

Worse	Small Imp.	Moderate	Large	Very Large	Unknown
4	4	3	3	2	3

Table 4 shows that about two-thirds of the families were from Trondheim, with the remainder coming from nearby communities. For practical reasons including time constraints, no families were selected who had received treatment in Tromsø.

Table 4 Place of residence

Trondheim	Nearby communities	Total
13	6	19

We see (table 5) that mothers predominate among informants. This is a common source of bias in interviews with parents that concern children. It only partly reflects that fact that some group participants were single mothers (table 6). Parents themselves determined if one or both parents would participate in the interviews, and mothers were often most active in the interviews even where both parents were present. Table 7 shows that the great majority of the children treated had one or more siblings.

Table 5 Informants

Mother	Mother & Father	Mother & Stepfather	Total
10	8	1	19

Table 6 Parent Training Participants

Mother	Mother & Father	Mother & Stepfather	Total
3	12	4	19

Table 7 Number of Siblings

None	One	Two	Three	Total
3	11	3	2	19

Table 8 Parents' Average Age

Mother	Father/Stepfather
34.9	37.1

Interviews were conducted October - November 2003, either home to the families or at The Regional Child Protection Research Unit, according to parents' own preference. Interviews lasted approximately 45 - 90 minutes. Participation was voluntary, and informants were paid a nominal fee (500 Norwegian krone). Information was treated confidentially, and parents received written information about the study prior to the interviews (see attachment). The interviews were taped and transcribed and form the basis of the data material analyzed for this study. Interviews were with either one parent (the mother), both parents, or a parent and their current partner who was not the child's biological parent. Children were not present during the interviews.

The design and the content of interviewing were determined by a desire to secure an *external assessment and evaluation based on parents' accounts and frames of reference.* None of the researchers involved, nor the interviewer, had training in the Incredible Years program and methods. Neither group leaders, nor researchers associated with the treatment trial were invited to contribute ideas or interview content. Interviews were administered with the help of a specially designed interview guide which enabled parents to provide a basically narrative account. Interviews were semi-structured to enable parents to relate their experiences in their own words as much as possible. The interviewer was provided with an interview guide with checklists to secure information about a range of issues (see attachments). Particular emphasis was placed upon allowing time so that parents' accounts could be given without undue prompting. The interviews were designed to elicit parents' own account of the entire process that began when they first experienced concern about their children's problems, through referral and treatment and beyond follow-up.

The interview material does have some limitations. The families were drawn from those who were treated in Trondheim in the first half of 2002. Referral patterns shifted somewhat during the course of the trial and these families may differ in some respects from those treated later. It is unfortunate that all are from Trondheim, but time constraints made it difficult to interview families treated in Tromsø. But over and above these limitations, it should be remembered that these parents have children with very pronounced behavioral disorders. All the children fulfilled screening and diagnostic criteria at the onset of treatment, and so they belong to a stringently defined clinical population. On that basis we would expect that many features of family life around a seriously disturbed child would occur in the sample.

The study's purpose was not only evaluative. We wanted to find out how parents experienced raising a child with serious behavior problems before, during and after Parent Training. The study is, therefore, both a user evaluation of a specific treatment - in

this case a 12-week parent training program "*The Incredible Years"* and a broader analysis of what it has been like for parents raising a child with serious behavior problems over time and the consequences this has had for them, for the child and for the rest of the family.

Among the topics which parents were asked to discuss were the following:

1. What kind of behavioral problems have affected the children, as the parents see these?
2. At what stage have parents recognized that their children's behavior is problematical? How and when were the problems identified?
3. What kind of support and guidance do families receive before they enter the program?
4. What help did the family want before starting training?
5. How do the (untreated) child's problems impact upon parents and other family members?
6. What are their impressions of the Parent Training program?
7. How have parents responded to the requirements that the program involves?
8. Are there aspects of Parent Training that they find particularly useful or rewarding?
9. Are there other sides to Parent Training that are difficult, seen from parents' point of view?
10. What are the main principles for dealing with and relating to the child, which parents have learned during training?
11. What skills did they learn?
12. Do parents practice the techniques they learn during Parent Training, after treatment is over?
13. How do they see their own situation and that of the child after follow-up (about eighteen months after treatment)? Has the impact of the child's problem on the family changed, and how?
14. How do they view the future for the child and themselves?

Interpreting the data

In-depth user evaluation material does not provide unambiguous findings. What parents tell us has to be interpreted, and there are a variety of problems of interpretation. In part these proceed from the fact that systematically organized qualitative material is highly specific and precise. It tells us a great deal about a limited number of subjects

and their perceptions. Users of services rarely get the chance to describe their experiences: but when they are asked to contribute, they usually tell us a great deal, a comprehensive account organized and structured around their perceptions and concerns. The material is of course not representative, and though it may display patterns, interpretation of these should be cautious.

In our work with these interviews, we were above all reminded that each family is different. Treatment is often and quite justifiably based on assumptions about common characteristics that those affected by a problem, will share, but when families who share the same difficulty are studied in-depth, they prove to be very different, with different experiences, circumstances, perceptions and concerns. On the other hand, we were also made aware that the structured and selective instruments used to assemble material in the treatment evaluation, involve a massive sacrifice of information. This loss is likely to include material highly relevant to assess the impact of treatment upon families, and their situation after treatment.

Chapter 2 - Parents' Experience Raising a Child with Behavior Problems - Before Parent Training

One important goal of this study has been to get a better understanding of how parents of children with behavior problems have experienced life with the child before starting the Webster-Stratton Parent Training program. How has the child's behavior affected them and the rest of the family? How have they tried to deal with the problem? What help have they received in this process? Little is known about the experience of such parents in Norway, especially their experiences prior to receiving help from children's psychiatric services.

There has been little research on children and young people with serious behavior problems in Norway. A report from an expert conference on this topic in Norway, states that an important characteristic of these children is their high level of aggression and lack of control of aggression (Norwegian research council, 1998). Representatives from Norwegian agencies in contact with children and youth including child protection, child psychiatry, school counseling and the police had the following description of children with serious behavior problems: substance abuse, delinquency, stealing, violence, destruction of property, use of threats, breaking of rules and norms, aggressive, acting out, restless, and living an unstructured life (Storvoll, 1997). This includes young people up to the age of 18, which is a much older group than the children in our study, who were between 4 and 8 years at the time of the program.

How did parents describe their children's behavior problems?

Parents were asked to describe their children's development from early childhood, particularly from the time they began to be concerned about the child's behavior. Despite the fact that this meant looking back on events as much as ten years in the past, parents had little difficulty in recalling and describing years of often painful experience, as well as specific incidents that had clearly left a lasting impression.

Parents in this study describe two principal types of behavior as most characteristic for their children:

1) A*nger and aggression* directed most frequently at family members and other children
2) V*ery active, restless, impulsive behavior* which can endanger the child himself and is especially challenging in group situations such as preschool and school.

These two behavior patterns are not mutually exclusive, and many of the children displayed both types of behavior. Other troubling behavior described by some of the parents include oppositional behavior, such as difficulty in getting children to listen and follow instructions, particularly in connection with routine situations in the family such as meals, getting dressed, going to bed, hanging up clothes, doing homework etc. Transitional situations were a particular problem for many of these children, such as when they were expected to stop what they were doing and come to the table at mealtime. Some of the children had additional developmental problems in particular with bedwetting or poor bowel control and learning impairment. Common to all of the families was the negative impact of living with a child with serious and chronic behavior problems, which had clear consequences for both the family and others in contact with the child.

Anger and aggression

Nearly all the parents had struggled with their children's anger and aggressive behavior. This anger was often directed at parents, siblings, and other children and sometimes at other adults such as teachers at preschool and school. While occasional anger, arguing, and fighting is not uncommon for children at this age, the frequency, duration, and intensity of these children's anger and aggression was clearly a serious problem for many of these families.

Conflict with siblings and other children was common, and once in conflict these children had little self-control. Arguing, hitting, fighting, throwing things and destruction of property were reported by many of the parents, and many told of receiving complaints from preschool or neighbors because of their children's attacks on other children. This could lead to exclusion by other children, who were frightened by such aggression, as in the case of this child below.

> “He was often in conflict with other children. He could get angry and just throw things and have a real tantrum. He had no limits when he was angry, it didn’t matter who was sitting there. Other children might save it until they came home or wouldn’t dare to act that way in front of strangers, but he had no such limits. He could be mean with his siblings and with other children. It was mostly because of his disposition. We thought he was very angry, he was angry almost all the time. It was the only emotion he could show. When he was sad he acted angry, and when he was frightened he acted angry, and when he was disappointed. That was in a way the only thing he could use. Interaction with other children was difficult; he didn’t have the social instincts that helped him to understand how to be included by other children in their games. He wasn’t able to handle it when the others didn’t understand what he meant, and he wasn’t able to explain how he wanted the game to be, so he got very angry when the others didn’t understand”.

Some children were easily provoked, making them easy targets for other children’s taunts and teasing. Other children knew just what buttons to push to provoke these children into a sudden temper tantrum.

> “He’s always been impulsive and done things without thinking first. If he got angry at someone, he could pick up a pencil and threaten to stick it in their eye, and if no one was there to stop it he could really have done it. He often attacked other children he was playing with. Then they wouldn’t play with him anymore and he was excluded. After a while they started taunting him, because they knew how angry he could get and it was so much fun when he chased after them. In a way, he became the big bad wolf”.

Parents described children who were often angry for hours at a time. This happened at home and other places like preschool.

> “He could be very angry, furious, from early in the morning because we woke him up the wrong way, but we didn’t know how he wanted us to wake him. He could stay angry the whole day. Everything was wrong. There were many conflicts. He fought with his siblings almost every day. We heard from his preschool that he was a problem there. He’d hit, pinch and kick the other children”.

It took little to trigger these children’s anger, and overreaction to the most trivial events was not uncommon.

> “He would get terribly angry over very small things. It could be that he didn’t get the kind of sandwich he wanted, or that it was made in the wrong way. Then his whole world fell apart. Little details that most people wouldn’t react to were enough to set him off”.

Once angered, these children could be withdrawn and difficult to communicate with.

> “Things have been difficult ever since he started preschool because of his anger. He gets all knotted up; it’s like he locks himself up in that feeling and gets totally black in his eyes. You can’t make contact with him, you can’t reach him somehow, and it’s very painful for him, you can tell by looking at him that he’s really suffering”.

Very active, restless children who need to be constantly watched

The second most common behavior problem described by parents was very active children who are restless, easily bored, often with a short attention span and poor concentration. Many are impulsive and engage in reckless or dangerous activity, often without thinking of the consequences. They are demanding and require constant attention from parents or other adults to prevent them from hurting themselves or others. This can be particularly exhausting to parents who feel they can never relax or let down their guard as long as the children are awake.

They are particularly difficult in groups or structured situations, such as at preschool or school, where their high activity level and impulsive behavior can be very disrupting. They have difficulty in sitting still or following basic routines, like staying at the table at mealtime or sitting at their desks at school. Transitions are also a problem for many of these children, such as when they are expected to finish one activity and start another.

Some of these children had seemingly limitless energy, which was exhausting for parents who needed to look after them continually. Even a short nap could be sufficient to recharge their batteries. This mother compared her son to a motor which ran constantly.

> “He was very dependent on our being with him, sitting with him and playing. He very rarely played with things for very long, he was interested for five seconds. He could never sit and play with Lego; that was just wishful thinking. He would rather do something physical, run and climb trees... He’s a little different now that he’s nine, but when he was younger, from the age of four or five, he was totally wild, he

> couldn't sit still unless he was watching TV... He couldn't just sit down and relax, and he never ran out of energy or got tired. I've never heard him say he was tired. I've very rarely seen him tired. He slept little, even when he was a little baby. I remember when he was two years old if he slept for ten minutes in town then it was trouble. If he slept for ten minutes it was as if he'd been asleep for seven or eight hours. That's how I remember it. It was exhausting. He had periods after he started school, he could have been about seven, when he never slept. It was like a motor that was running all the time. He was hungry all the time too; he was having a hard time. He never got turned off either mentally or physically. His motor just kept going constantly".

Some parents told about their children's dangerous behavior, which required constant attention in order to prevent them from harming themselves or disturbing others.

> "She was very demanding and exhausting as a young child... She was very restless. If someone spoke to her and asked her to stop fidgeting she could sit calmly for quite awhile, but if nobody said anything she would get more and more restless. She probably needed attention and wasn't able to stop acting up by herself... They had her under observation at school (because of suspicion of Tourette syndrome) and we used to get reports that she was very restless in transition situations, and often starts some sort of trouble... She has an active imagination, and we were always afraid of what she might do next because she did so many strange things. One time she and a friend climbed up in the window at her after-school program and she took off her pants and peed out the window... She got some of the other children to run away from school. She lit matches and took my cell phone to school. She does a lot of strange things. I'm always worried that she may do something dangerous. When she was seven or eight she threatened that she would jump down the stairs at school, and would take her own life. She's stopped doing some of the most dangerous things after the program, but she still does a lot of strange things. All children do that type of thing occasionally, but she does much more, and stretches the limits further than other children".

High activity levels were sometimes combined with poor concentration and difficulty obeying.

> "He slept very little when was young. He was good at going to bed on time, but he was very active during the day, always climbing and that kind of thing. He had no sense of danger at all, which was something they noticed at preschool too. They were the ones who thought he should be observed by a special education teacher. He was active, children should be active but within limits. He's always been kind and thoughtful, but you need to set definite limits for him, and he's always

been that way... He hasn't received a diagnosis, but his tests show that he has problems with concentration. He can't concentrate, and that's what prevents him from functioning 100%. He's not able to listen to our instructions, and never does what he's asked, and he's always been that way".

Oppositional behavior

Some parents were also concerned about their children's defiance and lack of obedience. This was mentioned less frequently than either anger/aggression or hyperactivity/restlessness. Parents described children who were unwilling or unable to follow basic instructions, for instance in connection with routine activities such as sitting still and eating at mealtime, keeping belongings in order, doing homework, or going to bed without a battle.

> "He won't listen to what we say. He just won't do the things we ask him to do, even simple things like coming home, keeping his school bag in order, or taking out his lunch box. I've said this to him every day since he began school, but he still can't manage to do it. And if we sit down to do his homework, he can't manage that either. I have to sit down with him and tell him - you have to do this. We're going to do this now. But it's always crying and shouting, each time he's supposed to do his homework".

These children were skilled at testing limits and provoking their parents. Parents responded with scolding and anger which only increased these children's defiance.

> "She really stretches limits. It's useless trying to get her to do anything. She never does what she's asked right away. There's lots of nagging and scolding before she finally gives in. She never listens and won't do the tasks I give her, like putting her things away... It doesn't matter if we're in public either; if she's irritated with me she can call me stupid even if there are a hundred strangers present. She really likes to test my limits and see how far she can go before I get really angry. It's a struggle all the time".

Children's stubbornness was a problem for some parents.

> "He won't take no for an answer. He never gives in, and never learns the consequences of things... It's worst when he's tired and he doesn't get his way. Like recently he didn't eat his lunch and he was very hungry, but I want him to eat at mealtimes and not in between. He can't manage to learn that".

It is interesting to note that fewer parents described disobedience and defiance as a cause of concern than anger/aggression and hyperactivity/restlessness. This result is somewhat counterintuitive, since one would expect that disobedience and defiance which are quite common for many young children aged eight and younger, would also have been a major problem for most of the children in our study. Parents interviewed for our study were asked to describe aspects of the child's behavior which had been a source of concern, and to give specific examples of such behavior. They were not asked to give a comprehensive description of all types of problem behavior displayed by their children. Parents' greater emphasis on angry and aggressive behavior and hyperactivity and restlessness does not necessarily mean that these children were not also disobedient and defiant. It may indicate that parents had a greater tolerance for disobedience and defiance, which they considered to be more normal, less serious, and easier to deal with than other more extreme behavior problems. This interpretation is consistent with parents' descriptions of frustration, exhaustion, and resignation. These were caused by having to relate to children who were either in frequent conflict with siblings, other children and adults, and/or to children who required constant supervision because they couldn't be left alone for even short periods without engaging in disruptive, dangerous, or provocative activity.

How and when was the child's problem identified?

It is now widely known that children of preschool age (six years and younger) often display behavior which is troubling to adults, particularly parents, preschool teachers and child care providers. Parents and teachers report concerns about eating, toileting and sleep problems, as well as management difficulties, hyperactivity, inattention and relationships with peers and siblings (Campbell, 1994).

The children in our study were between the ages of four and eight years at the time they started the Webster-Stratton Parent Training program, with the majority being six years or older. In most cases, their parents had been concerned about the child's behavior for at least several years before they started the program. Some parents struggled with their children's behavior already during their first few years of life, as illustrated by comments from these parents below.

> "She was very calm until she was one year old, and then she learned how to walk. Since then it's been non-stop. She gets very angry. It doesn't take much going against her before she gets really angry, and then she really explodes, and I mean explodes. Then the only thing to

> do is to send her to her room and let her stay there until she calms down".
>
> "He was very active already while I was pregnant. He slept little until he was three. He lay all hunched over and would just cry. He had lots of energy and was all over and I really struggled with him... He's a tough nut to crack, and must be kept under control at all times. I'm never able to relax".
>
> "He was active. He started walking at an early age. He rolled over on top of all the other babies when he was three months old. He never sat in my lap, and snuggled or anything like that. We didn't really react to it, but he was full speed from the beginning, and I noticed when he was older that he couldn't lie still on the floor, or we couldn't stay home for the whole day. Sometimes I would take him to the shopping center and push him around in his stroller so that there was something going on around him. It was very clear that he was easily bored".

Other children's problems emerged a little later, generally by the time the child was 3 - 4 years old, and almost always before they started school at age 6. Some parents saw the emergence or worsening of the child's problems as a response to changes in their life, in particular the parent's separation or divorce, the birth of a younger sibling, or starting preschool. Several parents described extreme jealousy after the birth of a younger brother or sister.

> "He was a completely normal and agreeable child until his younger brother was born when he was three and a half. The problem started during my pregnancy (with the younger brother) when he totally rejected me. He wouldn't let me look at him, touch him, or dress him and it got worse after his brother was born. We were very frustrated, and it just got worse. He hated his family, was angry and sad and hit other children at preschool. There was lots of trouble at preschool. ... We tried different things, and asked him what was wrong, but children that age have trouble expressing themselves. It was always difficult at bedtime, he'd cry, and one evening I said to him, we think it's hard for you because of the new baby, and he just said yes".

All the children in our sample attended preschool, and it was often here that parents believed the child's problems had started or worsened. A number of these children had difficulty making the transition from being cared for at home by their parents or by a nanny to the more challenging environment of the preschool. Here they had trouble interacting with larger numbers of peers in a group situation. Some of these children responded aggressively and were rejected by the other children. Preschool teachers

were often the first adults outside the family to confirm parents' fears about their child's behavior. The two descriptions below provide clear illustrations of this difficult transition.

> "His problems began at preschool. The first two or three years after he was born went reasonably well, but then I started school, and that was tough. He had a nanny first whom he liked a lot. She took care of several children. I think there were too many children in one place for him at preschool. In the beginning he struggled to fit in with the other children and there were a lot of conflicts. He was also difficult to deal with at home, and it got worse after his sister was born. I didn't have any trouble with him in the beginning but then he just started getting angry. He'd have these terrible temper tantrums. I had a very good dialogue with his preschool; they reacted to his behavior too, so I felt it wasn't just me. They said he functioned very poorly socially and was often naughty. The other children starting calling him naughty X. It wasn't very pleasant".

> "The first signs of her problems came after she started preschool. They were the first ones to talk to us. She had a nanny first and had a few unfortunate experiences there so we took her out and enrolled her in preschool. She started preschool a little late, and she was already a bit restless, and that was enough to create conflicts. There was an awful lot, that's where the problems started. There were a lot of conflicts with the other children. She was an only child so she was not used to playing with other children. She was very much alone and wasn't accepted by the other children. She tried to force herself into the group with the other children. She couldn't just be a passive participant; she had to lead the group. The other children couldn't handle that, so she became very unpopular. They wouldn't let her join in, and then she tried to force her way in by pushing aside the weakest one. There were lots of tough periods, and it was very exhausting".

How did children's behavior problems affect their parents and other family members?

Previous studies have shown that there is a clear correlation between family adversity, as reflected by such factors as maternal depression, marital discord, and other stressful life events, and the existence and persistence of behavior problems in young children (Campbell, 1995). Several of the mothers we interviewed talked about serious disputes with their former husbands and the negative consequences these had for their child.

One mother who was involved in a bitter custody fight with her former husband described the problems this had created for their son.

> "The transition has been really tough. He acts out a lot, with hitting, and kicking and cursing, and what comes out of his mouth is not normal for a 10 year old. But things were calmer during summer vacation; we did a lot of positive things to relax. But then he started school again which was a new challenge. It went well at first, but then he had some episodes of acting out. I think it's partly because his father contradicts what we tell him. If I tell him that it's we adults who are going to handle this (the custody battle), and it will be okay, and you shouldn't get involved because it is we who are going to find a solution. It will take a little time, but it will be okay. But his father sits there and tells him about his hostility to child protection services and that he's going to hire a lawyer, and that he'll be able to move back to his father. He plays with his mind, and it gets on the boy's nerves. He's dragged back and forth. That really makes me mad; it's we adults who should deal with this. I'm the one who's in charge now. It's that simple. He (the father) really makes me mad".

Causation can go in both directions, however, and most of the parents we interviewed talked about the heavy burden that their child's behavior problems had placed upon them, and upon the rest of the family. It is well established that parents of children with serious behavior problems are in a very difficult situation and often react with stress, depression, anger, and resignation (e.g. Patterson, 1982; Wahler and Dumas, 1984; Webster-Stratton, 1988, 1991). A qualitative study of parents of children with serious behavior problems describes a "ripple effect" where children's behavior problems generate stresses that negatively impact parents and others in contact with the child (Webster-Stratton and Spitzer, 1996).

> "Our qualitative data revealed that the conduct-problem child's behavior introduces significant stresses into her or his family system and, moreover, that these stresses have a cumulative effect on the parents. Parents' descriptions of the impact on their lives of their child's conduct problems suggested an image of ripples in a pond that widen until eventually the entire pond is affected. The child's behavior has consequences that radiate outward from the child in ever-widening circles, affecting first the parents, then the marital relationship, then other siblings, then the extended family, and then the family's relationships with the community (Webster-Stratton and Spitzer, 1996, p. 21 - 2)".

Many of our informants described a similar pattern, where the burden of raising a child with serious behavior problems has had serious consequences for themselves, the rest

of the family, and for others. They described angry children who required constant attention, often from an early age. These children were the main focus of their families and dominated much of the family's daily life. Parents were often the main target of the child's anger and hostility, leading to tense relationships between parent and child and frequent conflicts and confrontations. Parents were often unclear about the nature and seriousness of their child's problems and didn't know how to deal with them. Many parents talked about being constantly exhausted after years of trying to deal with their child's behavior. Some felt trapped in a cycle of anger and constant scolding which led to increased resentment and rebellion on the part of the child. One mother described the difficult situation her family was in before they started Parent Training.

> "Things were tough. We were very sad and so was he. Everything was just miserable. There were few bright spots. He was aggressive and we were too because we couldn't handle it. Everyone was really upset. It's hard to remember specific examples. Looking back it's like a permanent fog. He would never take no for an answer. He would never give in, and never learned the consequences of things. We have the same problems now but we tackle them differently, so he also tackles things differently. It was hell with hysterical rage and things like that, so by the end we adults were angry too. We raised our voices and he would get a whack on his fingers. It wasn't very pleasant... It left me totally exhausted, and of course there was a lot of quarrelling between me and his stepfather. We ran into situations where we disagreed because of my son".

Another mother recalled problems with her daughter, particularly related to toilet training.

> "I think I handled her behavior very badly. I didn't really know what to do. I was locked in a routine of nagging, scolding and criticizing all day long. That was basically the situation and it didn't help, it just got worse. I didn't know what I could have done instead. I decided I just had to keep on nagging, especially about toilet training and things like that. So we were really locked in the situation. That's surely why she's so immature in so many areas. When the other children advanced from toilet training to the next stage, we were still trying to teach her toilet training. There are many things she might have been able to learn to do on her own, but I did them for her because I didn't feel like nagging anymore".

The burden of raising a child with behavior problems created stress and tensions which affected all family members. Parents had too little time and energy for themselves, for each other, and for their other children. Parents talked about marital relationships that were threatened by the difficult situation they found themselves in, and some of the

couples did break up, in part because of the stress of handling a child with serious behavior problems. Some parents disagreed about how best to deal with the child's behavior. Such disagreements were confusing for the child and damaging to the relationship between the parents.

One mother told about the problems she had cooperating with her son's stepfather, who didn't understand his problems and refused to participate in Parent Training.

> "The problem for us is that I am living with someone (stepfather) who doesn't really understand my son's problem; that he's unable to take in all the instructions we give him. We didn't realize that he had concentration problems which were preventing him from listening to what we told him. After all the tests and examinations he's been through, we've found out that is the problem. His stepfather still says 'why doesn't he bother to listen, and why doesn't he do this and that like we tell him'. He's not his real father, and he thinks that he just does whatever he pleases, and never does what we ask him to. He says 'he's sloppy as a pig', that sort of thing. He's never been to the Parent Training program or to the child psychiatry department either. He just won't do it; he thinks it's a waste of time. ...We've talked about it, but he hasn't followed up very much. It's been two steps forward and one step back. It's helped some, but I think about how much more it could have done if we were able to work together a little more. In my group all the other mothers were sitting there with their partners or grandparents, and I was all alone".

All but three of the families interviewed had more than one child. Siblings of the child with behavior problems were often negatively affected in various ways. They were often the targets of the difficult child's anger, aggression and violence. Parents described households characterized by high levels of noise, tension and frequent fighting between siblings. Some siblings were expert at pushing just the right buttons in order to provoke an outburst from the 'problem' child. Many parents talked about the difficulty of giving enough attention to the siblings of the child with problem behavior. They feared that the other children would learn from and copy the negative behavior. Some siblings were forced to assume too much responsibility in relation to their age. They tried to help their parents to raise the problem child, acting as mediator or surrogate parent. Several of the families had more than one child with serious behavior problems. One mother talked about the difficulty of raising four strong-willed children, when one of them has serious behavior problems:

> "All our children have very clear opinions about what they want and don't want, strong wills and pretty strong temperaments too. So it's

> very easy to understand what they want. That's good but it's also a little tiring. Our oldest daughter has always managed very well. She is very easy-going and nice and she supports me when things get out of control here. She helps me with X and is very good at diverting him. Sometimes she acts like his substitute mother. I try to avoid letting her do that too often. She has to be allowed to be a child too. But she is the big sister and handles that role really well, I think. He has a very good relationship to his big sister.... The two boys are like a powder keg when they are together, so things can get pretty explosive sometimes. It's been a while since he's fought a lot with his brother. There were periods where they almost couldn't go past each other in the hall without starting to fight. There were periods when I tried to get one of them to eat first because there was always quarrelling during meals, which was really unpleasant. It was worse earlier in the summer, now it's a little better, but they still both have really short fuses. He teases his brother and he explodes, or the other way around of course. But the one he has the biggest problems with now is his little sister because he thinks she's a pest and that she's stupid. Goodness gracious, he almost blows up. He thinks she's so hopeless lately. There's no limit to it. But it goes in phases, in a way that's the lesson I've learned from all this, things like that get straightened out after a while. I'm not that worried about it anymore. It's unpleasant because they say ugly things to each other, and it gets pretty tense here. And the little one absorbs all this, so it's not always so nice. But that's how it is right now and it'll get straightened out after a while, I think".

Many of the parents talked about frequent fighting between siblings. Often the child with behavior problems was the aggressor even if they were younger. Parents felt trapped in a difficult situation.

> "I struggled a lot. I used a lot of time on X and focused most on the negative. There was a lot of scolding and shouting - 'now you pooped in your pants again'. There was a high noise level in the family, and lots of fighting all the time between the two oldest boys. It was really difficult for my oldest son because his little brother hit him all the time. I had given up a bit. I was very tired of X's mood swings. I tried talking to him but it never helped, it just got worse. We were locked in the situation".

Relationships to other relatives could also be difficult. Sometimes grandparents, aunts, uncles and other relatives did provide needed support and relief for parents as baby sitters. But many families struggled with this because relatives didn't understand the nature of the child's problems and often blamed the parents for not doing a better job

of parenting. One mother talked about strained relations with relatives who did not understand her son and his problems.

> "It's very difficult to visit others, not just the family, but especially to my mother and my sister who think my son is just a spoiled brat. They couldn't see that he had a problem, and they blamed me for his conduct. I didn't get any support from them. I've cut off contact with them now, it was really very difficult. I tried several times to explain how they should relate to the boy, but it didn't help. I could see that this bothered him. Whenever we went to visit them he was very insecure and almost out of control. He wasn't able to show them his good side. I chose to protect my son, so I see no reason to have any more contact with my mother and my sister".

Many parents talked about feeling responsible for their child's behavior problems. They felt inadequate as parents and guilty about not being able to relate to their children in a more positive way. Some were ashamed of how others reacted to the child and to them as parents. These feelings were often reinforced by critical comments from relatives, neighbors, teachers and others. They blamed the child's problems on parents who could not control their own children.

> "We got negative comments about him all the time. From the teachers too, they rarely said anything positive. There was a lot of negative feedback during that period. It's possible they said something positive, but at that time there was so much negative that if they said anything positive we must have missed it. It doesn't help to say your son did a good job today, but, and then say something negative afterwards It was like huff, what did they write in his book today, when we came to pick him up. It was really tough to always hear bad things about your child. I don't understand why they said so much negative. It shouldn't be like that".

Many families became increasingly isolated as parents found it difficult to have visitors or make visits because of their child's unpredictable behavior. Family gatherings with friends and relatives were challenges and a source of embarrassment which brought out the worst in some of these children.

> "It was the isolation that was the most exhausting, we never went anywhere. It wasn't possible. He just made a spectacle of himself. We went on occasional visits but they became less and less frequent. It was so exhausting because we had to watch him the whole time... When we were outside in the neighborhood we heard things some-

> times. X did this and that, with the implication that we weren't strict enough with him, that we didn't discipline him enough".
>
> "We were constantly tired. I didn't have enough time for his younger brother. Everything revolved around X. I dreaded taking him on visits, and I didn't want many visitors because I was exhausted. I knew that if anyone came to visit he would get so wild and excited, and when we went to visit others it usually ended up with a tantrum, so I just had to pick him up and leave. I think that was terrible. It was like - 'my goodness, can't she manage to take care of her own child?' They didn't understand that he had a diagnosis (ADHD) because he looks perfectly normal. It's a hidden handicap".

Visits to stores, restaurants, movies and other public places, which most parents take for granted, were an especially trying ordeal which parents dreaded.

> "Taking her to stores was always a difficult situation. I heard this was also a problem for some of the other parents in our group. We were definitely not the only ones. Taking her shopping was extremely tiring because she would always try to explore the whole store at once. She would run around and take things from the shelves and she got her sister to join in. There were times when we were dripping with sweat and exhausted after those trips. We felt that everyone was staring at us. There was a commotion the whole time. We tried to hold them, and they just shouted 'ouch, stop pinching me'. Everything about it was a real nightmare. It was tiring, really tiring".

What help did parents receive before starting Parent Training?

The Webster-Stratton Parent Training program was targeted at parents of children aged 4 - 8 years, and most of the children in our study were 6 years or older by the time their parents started the program. By this time, most parents had been aware of, and concerned about, their child's behavior for several years, generally by the time the child was 3 or 4, if not earlier. Despite this, most parents had received little effective help in managing their children's behavior, or in defining more clearly what was wrong with the child. Many parents had been in contact with various community service agencies providing health care, social services, educational and counseling services. Though service professionals were generally well-intentioned, they usually had little to offer in the way of structured programs designed to help parents raise children with serious behavior problems. Parents also had trouble obtaining adequate information about the nature of their children's problems. Some of the children eventually re-

ceived diagnoses for conditions such as ADHD and Tourette syndrome, but this was usually after they were done with Parent Training. Community service workers often lacked the expertise or authority to define the problem more clearly. For most, Parent Training was the first meaningful assistance they had received to help them manage their child's behavior better.

Most parents had been in contact with community services before starting Parent Training and some did receive some help from these, particularly from preschool. Parents talked about various helping agencies they had been in contact with during this period including preschool, school, public health centers, other health care services, school counseling and child protection. These latter two services are part of the same agency in Trondheim, where most of the families we interviewed lived. Some of the families received health care services for various other problems the child suffered from including hearing and vision, allergies, toilet training problems etc.

All the children in our study attended preschool, and this was a service which many parents found helpful, both for the child and for themselves. Though most parents seemed reasonably satisfied with the help they had received from community services, this was not something they discussed in much detail, and it did not seem to have helped them to handle their child more effectively. Some parents were openly dissatisfied with help they had received, or had wanted but not received. Sources of dissatisfaction included too little help in identifying the child's problems, with advice about how to handle the child, with turnover among agency personnel, and with uncooperative or incompetent helpers.

Preschool was the type of assistance described most often by parents, and most were satisfied with this help both for themselves and the child. Preschool provided parents with time away from the burden of raising a difficult child, and the opportunity for parents to pursue other activities including work and school. It gave the child the opportunity to get out of the house and to play with other children under the supervision of trained personnel. Though many of these children struggled to adapt to the challenges of interacting with other children and staff in a more structured and demanding preschool environment, parents generally felt that staff did a good job of trying to help the child to fit in. Some preschools were able to secure extra personnel and special education staff to work with the child one-to-one or in smaller groups. Preschools also helped to refer the families to other services, including school counseling, child protection, and sometimes to Parent Training itself, though relatively few of the children were referred directly to Parent Training from preschool.

Preschools also played an important role in confirming or clarifying parents' suspicions about their child's behavior. Parents were generally aware of the child's behavior problems before they started preschool, but they were often unsure what to make of them. Preschool staff who had more experience with different types of children, were often able to give parents useful advice about their child. They were sometimes assisted in this by specialists from school counseling or child protection who were asked to observe and assess the child. This mother talked about the good help she and her child received at his preschool. She especially appreciated the chance to talk with staff about her son's problems and how to deal with them.

> "They tried very hard to get him included in the play group, but he usually just stayed together with one or two of the children. The staff did a good job with him, and one of them gave him special attention, took him out of the group sometimes to help him calm down... The staff helped me too. We had good communication. If I was worried about something I could tell them, and they arranged a time when we could talk about it. We talked about what could be done about the problem and they were very good at following through afterwards. They told me about how his day had been and how he was doing. It was mostly about problems, but they also told me about positive things. When you are in that kind of situation and don't know very much, because he hadn't been diagnosed yet, it's really tough... I learned in the beginning at preschool that his behavior was not normal. I had never had a child before, so I thought maybe it was normal. So when they started reacting at preschool he was two and a half I think or maybe three years old. His behavior was assessed, and he got his diagnosis (ADHD) when he was five years old. Before that I just thought it was difficult raising children, I had always believed that. But I noticed a big difference when his brother was born; he has a totally different personality".

This child was diagnosed with ADHD before his parents started the Webster-Stratton program which was unusual. Several of the other children in our study received diagnoses for ADHD, Tourette syndrome, brain damage and learning disability. Most of these were not diagnosed until after Parent Training was done. School counseling and child protection services were sometimes called upon for assistance in assessing the child's problems, as in the following example.

> "Her teachers at preschool were the ones that reacted when she was five years old. They wanted to have her observed by child protection because there was something wrong with her behavior. She'd do things like push the other children, which we took as a sign that she wanted to get to know them, but didn't know how to do it... She also

> started hitting the other children, or knocked down their building blocks, things like that, totally unprovoked".

Some families like this one were satisfied with the help they received from preschool, school counseling and special education services.

> "Starting preschool was difficult for him. He didn't like it and cried a lot. It wasn't getting any better, and he wasn't adjusting well. When he was four we had a meeting with his teacher at preschool. I asked them whether his temperament was normal. They also wanted to discuss this because they thought the situation was difficult and they were having trouble making progress with him. They wanted advice about how to handle him and contacted school counseling. They brought in a psychologist who observed him and gave the staff supervision. They then arranged for special education help for him for several hours a week. So they really helped him, and we were really happy because we'd been wondering is this ok, is this normal? We really wondered about. It took longer with him than with our other children, and even though we felt like we were dealing with it in a way, he was always the worst".

Schools were also helpful for some of the families. This mother was glad that the school understood and dealt with bullying.

> "The best help we got was from his school. I was most pleased about the way they stepped in, especially with bullying, and that they accepted that as a problem. When I went to school that didn't happen, because I was bullied too, and that's why I'm especially aware of his problems with bullying. I know how it is, so it's really important to me that they were able to deal with it".

Another mother was pleased with the positive influence of his teacher on her son.

> "We have really good contact with his teacher. He's a very good influence on our son, and he really listens to his teacher. He tells us that the teacher told him 'to do this or don't do that' and he does what the teacher says. He doesn't listen to the special education teacher who teaches him Norwegian at all though. I think she talks too much for him".

Some parents were more dissatisfied with help they had received, or with help they had wanted but not received. A few complained about incompetent or inexperienced staff who were not able to provide quality assistance, or about high turnover rates that reduced continuity of care. Some felt that they were being unfairly blamed for the

child's problems, rather than being seen as a resource to help the child. Some talked about having to fight to get proper help for the child, often over the reluctance or opposition of professional helpers. Some parents had trouble getting help in identifying the real nature of their child's problems, and some received mistaken advice about the causes of the problem, and its seriousness. This was especially difficult for parents who had no previous children with whom they could compare the child's behavior. They were unsure about what was normal behavior for a child at a given age. Two-thirds of the children with behavior problems in our study were first-born, like this child below.

> "No, not really, she would very quickly become angry, but I didn't think she was special. Everyone said it's just her age three, four, five years when children become quickly angry, a defiant phase that will pass. I'd never had any children before, so I believed, or at least I wanted to believe that it would pass. Nobody told me any differently, and she didn't start preschool until she was three and a half, and they didn't say anything at first".

Some parents did not get the help they wanted because their child's behavior problems were misunderstood. This child's behavior problems were first blamed on sibling rivalry and later on poor hearing.

> "When he was two years old he was very active. Then he got a sister when he was two and a half. After that it was so easy to blame it on sibling jealousy when we talked to them at the public health clinic. I told the nurse that I thought he was a little impossible and difficult; he's high and low all at once. But the nurse said no, 'it's perfectly natural when a child has just gotten a sibling, its typical sibling jealousy. You'll see, he'll outgrow it in awhile. He will calm down when he gets used to the situation'. But when I think about it now looking back he never became normal. And we had no one to compare him to, because he was our first child... After his hearing was corrected it was so easy to blame his other problems on that. It was his hearing that had caused him to act the way he did. So now his behavior will surely improve... It got a little better for a while, and then it was so easy to say that everything was much better, and that his problems will now surely disappear. But his problems didn't disappear. We applied to delay his starting school for a year. It was discussed several times with the school nurse and doctor and the principal, but they said no, now that his hearing problems are corrected his behavior will surely improve. All the others thought the behavior problems would disappear. But I said, 'no, I don't believe that, that's not all that's wrong with him".

Not all families were satisfied with the help they received from preschool. These parents blamed incompetent staff for their son's poor care.

> "I was very sad when I came to pick up her up at preschool because there was always something new they complained about. It was really terrible; the friends she made were very unpopular. The personnel at preschool were a little too old, and they also had some newly educated staff who still didn't know what they were doing... The staff thought that all the children should behave the same way, and when they got a child like our daughter who was more active they didn't know how to handle it. It was too much for them, and then we got all these negative comments. 'Today she did this or that'; they had such an angry attitude. I was really sad, terrible".

Turnover was another problem for some of the parents.

> "I think we were a little unlucky with our preschool... They had three different leaders, one after the other. The first leader who our son was very attached to became pregnant, so they got a temporary leader, and she got pregnant too. He was quite attached to each of the leaders, and so he had to go through three separations from people he had felt secure with. That wasn't very positive".

Heavy turnover was also a problem at other agencies, including child protection services. This father was also disappointed in school counseling services which had misunderstood their needs.

> "We had an episode with school counseling services when we asked for help, but felt they had little to offer. My wife was going to school then which the counselors thought was a mistake. They said she should stay at home with our children. She asked what she should do while they were at preschool and school and didn't get home until four-thirty. The counselors said it was too demanding for her to go to school because our home situation was very chaotic. We didn't agree with this description. They reacted so negatively to everything we said and did that I'm not interested in cooperating with them. They just looked at the children's situation and couldn't see that parents need a life in addition to caring for children. They weren't interested in our financial situation either. That's why we contacted child protection. I was angry about their description of our family which did not match our view of reality. We were a little more satisfied with child protection, but things were pretty chaotic there too. There was a lot of changing of case workers and we had to repeat the same story to several of them. There was a lot of confusion, we had to relate to many

different people and sometimes it took a half year before the new worker took over the case".

How did parents learn about Parent Training?

A study of recruitment to the Webster-Stratton Parent Training program in Trondheim and Tromsø found that primary level community service agencies were the most active in referring families to the program (Tjelflaat et al., 2002). In particular, schools, school counseling services, child protection, and health services were the most frequent referral sources. Parents in our study were asked how they learned about the program and if they received help in applying. Parents sometimes mentioned more than one information source. Our results are similar to those of the above recruitment study, with two differences. Preschools and parents themselves were more involved in referrals to Parent Training than was the case in the earlier study.

Parents in our study all agreed to participate in Parent Training and most appreciated the information they had received about the program and help in applying. Some felt that more information about the program should be available, and that the program should be more widely publicized to all parents with small children, not just those with serious behavior problems. Some suggested that public health clinics, preschools and other places that had frequent contact with parents of small children should routinely provide more information about the program.

Most of the parents had not had previous contact with child psychiatric services, and some were initially skeptical about parent training organized by this unit. Several parents commented that they had thought that child psychiatry was aimed at children with more serious problems than those affecting their own child. Some were dubious about contacting child psychiatry for such a young child.

School counseling services and child protection referred most parents to the program. They were involved in referring half of the families to Parent Training. These services are part of the same agency in Trondheim and not all parents distinguished between them with regard to who had referred them to the program. Health services including doctors, public health clinics, hospitals and specialist services were the next most frequent referral source for about one-third of the families. About one-fourth of the families learned about the program on their own, often after hearing about it through unofficial channels such as newspapers and other media, or through friends and acquaint-

ances with children in the program. Some of these parents took an active role in applying for the program themselves, like the family below.

> "I found out about the program from a friend who had heard about the program at school. I called the child psychiatry unit because I thought it sounded really exciting. Then it was a nightmare getting his doctor to refer him to the program, because he hadn't heard about it. He didn't understand why we wanted to go there either, because he didn't think we needed it. So then I contacted the public health nurse and said 'I want to get into the program, I need a referral, so you need to talk to the doctor. I'll come tomorrow to pick up the referral.' That's the way it's been the whole time. The system is like that, if you don't stand up for yourself then you don't get any help. I'm sure if I hadn't pressed the nurse, I never would have gotten the referral".

Preschools were involved in referring about one-fifth of the families to the program. This is a relatively small proportion, considering the fact that all of these children had attended preschool, and that preschool teachers were aware of the problems. There are several possible explanations for the relatively low referral rate from preschools. First, the Webster-Stratton program did not exist in Trondheim before 2001, by which time some of these children were already in school. Also, many preschools have little tradition for referring children to child psychiatry, finding it more natural to deal with the problems themselves or to contact school counseling or child protection. This mother appreciated the help she got from her child's preschool in applying for the program.

> "After he started preschool we got feedback that he was asocial, gruff, and had poor concentration. The staff saw right away that something was wrong and that he needed following up from me, them, and other agencies. They were the one's that recommended the Webster-Stratton program. I'm really glad about that today. If I hadn't found out about the program it would have been much worse. I got very good support from both preschool and the program...There was a special educator at preschool who was terrific. If it hadn't been for preschool I don't know if I ever would have heard about the program. The health clinic never mentioned it. They only talked about a weekend family for him, and that wasn't any help".

Schools were involved in referring about one-sixth of the families to the program. This is less than in the recruitment study, and may reflect the fact that families with younger children were more heavily represented in our study. Schools may also have been involved in referring some families where school counseling made the actual referral.

Chapter 3 - Parents Views of Parent Training

The second phase of our interview with parents focused on their experiences with the Webster-Stratton Parent Training program. Our informants provided us with clear and detailed descriptions of their views about the program which they had completed 18 - 24 months prior to our interviews. For many of the parents this was the most substantive portion of the interview. While parents had differing views about some aspects of the program, a number of clear trends emerge.

The explicit goals of the Webster-Stratton program are to teach parents improved parenting skills which they can use to improve their interaction with their children and, thereby, improve their child's overall functioning and behavior. In particular, parents are taught to pay greater attention to, and to reward children's positive behavior. They are also taught as much as possible to ignore negative, attention-seeking behavior such as anger, violence and other anti-social behavior. Our interviews with parents clearly indicate that all were satisfied with the program and many were very positive, despite the fact that not all had improved their parenting skills and not all children had improved their behavior.

It is not surprising that parents who felt that the program had helped them to improve their parenting skills, and particularly those who felt that they had been able to use these skills to improve their child's behavior should talk about the program in positive terms. It is perhaps more surprising that parents who did not report these types of progress, were also satisfied, and in some cases very enthusiastic about the program. What benefit did they receive from the program? Parents felt that participating in a group with other parents who were in a similar situation, and who had struggled with similar problems provided a valuable source of support, and a much needed opportunity to share their experiences with others who understood what they were going through. This was a very important aspect of the program for most of these parents.

In this section, we discuss parents' views about the role of the parent groups. We will also look at their impressions of other aspects of the program including the referral process, the role of the group leaders, the usefulness of various program components including videos, role play, home assignments, group discussions, children's groups (dinosaur school), and filling out of questionnaires for research purposes. What parent-

ing skills did some parents acquire, and what impact did this have on the behavior of their children? What suggestions did they have for improving the program?

Importance of the parent groups

Though parents differed in their assessment of various aspects of Parent Training, two things all parents agreed upon were their overall satisfaction with the program, and the importance of their interaction with other parents in the parent groups. These two findings are clearly related, because for many parents this was the most valuable part of the program, which overshadowed for some the parenting methods themselves. The parent groups provided many of these parents with much-needed support, encouragement, and improved morale through their interaction with other parents who found themselves in a similar situation.

Parents described various benefits they received from the parent groups including social contact, being heard and understood, having the opportunity to share their experiences with others who had gone through similar experiences, giving each other mutual support and confirmation that they were not incompetent parents, and a forum for giving and receiving practical advice about parenting strategies which do and do not work with this type of child. Many of these parents had struggled for years with the difficult task of trying to raise a child with serious behavior problems. Many felt responsible for the child's problems and had serious doubts about their own parental competence. Many had not had previous contact with other parents in a similar situation. Many had believed that they were alone in having a child with this type of behavior, and alone in their inability to deal with it more effectively. The discovery that they were not unique, that other parents struggled with children with similar or even more serious problems, was clearly an important and positive experience for many of these parents. Parents found comfort in the recognition that what they had believed was a special and abnormal situation affecting only their family, was in fact a more widespread and more normal phenomenon. The parent group helped them to reduce their feelings of stigmatization and isolation. One single mother whose six year old son had trouble controlling his frequent anger outbursts expressed the importance of talking to other parents in the same situation.

> "It helped me a lot to talk to other parents who were in the same situation. I thought I was the only one who had a child like that. I got an answer to a lot of what I thought and felt myself, and shared sorrows and joys with the others in the group. I got really good help through the program".

For one couple, the discovery that other parents struggled in a similar way with their children's behavior problems was a critical insight that helped them to turn around a difficult family situation. They also got support in the group that they were better parents than they had feared. They learned that some of the parenting methods they used before starting Parent Training had been appropriate.

> "Seeing that there were others that had problems was tremendously useful. You felt all alone in the world when you were right in the middle of it. No one else has problems, just us. That period saved us and the children, our marriage and everything. Because we found out that there were others who were struggling too, who had problems, and that we had handled them correctly".

Taking comfort from the fact that one's own problems, however overwhelming they may appear at the time, are less serious than those of others is a familiar strategy. It was used by some of our informants who were greatly relieved to discover that other parents in the group had problems raising their children; problems which in some cases seemed worse than those in their own family. Some parents were quite open about the comfort they derived from this knowledge. One parent put it this way.

> "They were positive, but worried parents who struggled with their children, who need help. It was good to hear that there were others who struggled with things, you know what I mean; who I felt were much worse. Some of them were much worse, especially one child, because that child did so many strange things. He had no respect, absolutely no respect. He really controlled his family. And I thought, thank goodness, I feel like I don't have a problem compared to that family".

Another couple expressed similar thoughts:

> "In the parents group there were both single parents and also those like us with partners or spouses who struggled even more than us. So I felt that we had the least problems to struggle with compared to many of the others. There were some that had problems with children who cursed when they were only four or five years old and who had other bad habits which were more alarming than what we had with X, who just was a little restless when he was sitting. Compared to the others in the group I would say that it was just small potatoes what we had to deal with".

Parents participating in the Webster-Stratton program were recruited from diverse social and economic backgrounds. Some had previous contact with child protection and other social service agencies. Many of the families in our study were respectable married couples with middle class backgrounds. Some of the parents with more difficult situations including single mothers, unemployed, and social welfare recipients were relieved to discover that "normal" parents from respectable backgrounds also struggled with their child's difficult behavior. One single mother expressed the following:

> "The parent group was very good, in my opinion. It was really very alright to see that you weren't alone, that everyone said they were struggling too. To see that others are even worse off. It was good to find out that it wasn't just me who was a single mother, who struggled with that kind of problem; there were married couples and people with a lot of resources. That it wasn't just me that had troubles".

Another mother said:

> "There were people of all different social classes, and I really enjoyed the fact that there was everything from men in suits to men in flannel shirts in our group. It's not just for poor people; they're not the only ones with problems. That was a positive experience. The wealthier members of the group were actually just as nice. I think people were surprisingly open in the beginning. I was a little surprised by that. It proves that people were really interested in being there, they didn't just show up".

Another mother said:

> "For me personally it was meeting other people in the same situation and seeing that it's not just totally confused and apathetic losers that have children like this. It's actually completely normal people who have children that are struggling a little. And I came to realize that I'm not totally useless as a mother. I do have some use, ha, ha. So that was really good. And I got a lot of strategies or tools to use in connection with behavior which we wanted to eliminate".

Many of our informants stated that the most useful aspect of the parent groups was the chance to talk openly and to share experiences and feelings with other parents who understood what they were talking about. The groups provided a supportive atmosphere where parents were able to be honest about their children and the difficulties they encountered in trying to deal with their problems. Mutual support from other parents was the key. They learned that they were not bad parents, but rather struggling with a very difficult situation that would challenge the patience and competence of any

parent. This helped parents to feel better about them selves and to boost their morale. These parents were accustomed to being misunderstood by parents of "normal" children who did not understand what it was like raising a child with serious behavior problems. Those parents blamed them for the child's behavior. They exchanged advice about parenting approaches they had tried, about things that had worked and things which did not. Some parents felt that more time should have been devoted to these discussions with other parents and less time to video clips, role play and information from the group leaders. Some parents talked about the importance of being understood by others in the same situation, and receiving mutual support:

> "Finally, we met other people in the same situation as us, who had an equally difficult daily life and were struggling just as much. That was the best thing when the group started, to be able to talk about our problem to others who understood. Yippie, finally there's someone who understands us. I've spoken to other parents who aren't in the same situation and they have no idea what we are going through. We've gotten a lot of foolish advice".

> "Finally there's someone who understands what I'm talking about. I had never met parents who had children with that type of diagnosis (ADHD). It was very good to know that I was not alone. I'm still in contact with one of the other mothers. We give each other support. The group was very good, it really was. Receiving support and understanding was the most important".

Some parents talked about useful advice and tips they received from other parents in the group.

> "We found it very informative and useful. We told each other about things we had tried with our children that had worked for us. We gave each other a lot of advice, and a lot of it really helped".

Some parents found it difficult at first talking to a group of strangers about such private and sensitive matters. After they became better acquainted, it became easier to open up and to talk honestly about their children's problems and their own doubts about their competence as parents.

> "We were all reserved in the beginning. I didn't want to be seen as dumb because my son had problems, but it was good after a while to see that others struggled with their children and had similar problems, and that there are not just well-behaved children out there. We got better contact after we got to know each other and went out for coffee af-

> ter the program, but that's over now. It was really good to be in the parent group and to see that we were not alone. It's good that we were allowed to be honest, and that I could talk openly about my son's problems without having to put a better face on things, and without feeling ashamed because we weren't good enough parents. We were allowed to be honest and were accepted for that. The most important thing for me was to be able to be honest and to get a response, to feel that it was permissible to be unable to manage your child".

Some parents felt that discussions with other parents were the most useful part of the program and wanted to use even more time on this. Some felt that the program was too intensive and too structured, and that the need to cover the topics and material planned for each session left too little time for more informal discussions with other parents. Breaks during each session, when the parents were served sandwiches and coffee provided a welcome opportunity for getting better acquainted with the other parents and group leaders, and for informal discussions. Many of the parents were sad when the program ended. Some tried to maintain social contact with other parents after the program was over. Some of the groups did get together socially after the program, but this tended to be more infrequent as time passed. Many of the parents expressed the desire for some form of follow-up training or group reunion organized by the child psychiatry services.

> "I remember at first it was hard to start talking, but after awhile when you realized that everyone struggled with the same things to varying degrees, it became easier. We've gotten together also after the program, at home to each other socially, for dinner with a little wine and singing, and you feel so free and relaxed. It was very important to make contact with others who had gone through similar things. I understand that now".

> "I think the parent groups worked well. I feel that we got to know each other. I'm not the type of person who likes to talk with a lot of people around me, at least not people that I don't know, but I think it was really alright. The most useful thing about the parent groups was talking about the situation... I think the group was really good. We got together a couple of times afterwards; we went bowling among other things. I came into a good group".

Parents' views of the group leaders

The Webster-Stratton parent groups were led by two trained group leaders or therapists. These group leaders play a central role in the program. They have responsibility

for all aspects of the Parent Training including leading the training groups, making sure that all course material is covered and presented in a way that is in accordance with program principles and protocols, and helping to establish a positive group atmosphere. Parents were not asked during the interview to identify their group leaders by name, and this study makes no attempt to evaluate the performance of individual group leaders. Parents were, however, asked their opinion of the group leaders. All our informants had positive impressions of the leaders, though many did not go into this topic in great detail. Parents appreciated particularly the personal characteristics of the leaders, who they described as positive, warm, down-to-earth, engaging, supportive, and understanding. One mother said:

> "The leaders were really talented people. They know what they're doing. And they were very down-to-earth, people-oriented and sociable. They really need to be that way in that type of work. They have to relate to so many different kinds of people. They need to start carefully and see what the person they're talking to says, so they can respond in a way that's helpful. They were very good at that. They understood us well. During the breaks we used to talk a lot about different topics like what we would do in different situations. We always used extra time in the breaks".

Another couple said:

> "The therapists were super. I miss them. We should have had them here at home once, ha, ha. I have nothing negative to say at all. They were such lively, positive, and terrific people. It has to be the right therapists, they must not be boring and unengaged people who just sit there, that wouldn't work".

Parents clearly liked the positive and supportive attitude displayed by the group leaders during the group meetings. The leaders attempted to demonstrate for parents the same behavioral methods which they were being taught to use with their own children, including behaving positively, praising the parents for their accomplishments, and avoiding unnecessary criticism.

One mother said:

> "The leaders were very good. It seemed like they were so totally positive. We (the parents) came there and were tired, angry and depressed, but them, no way. I felt like I was in a nursery school, ha, ha. When they were so positive you became more optimistic yourself, it was contagious. They had probably had a terrible day themselves, but they

> came in with their smiles glued on their faces - now we're at work. The leaders demonstrated the way we were supposed to act with our children by treating us in the same way in the parent group. So that was positive too. Even though you are angry, you can still try to smile and try to be positive, you don't have to let it ruin things for others".

Parents responded to the personal attention they received from the group leaders and to the supportive, non-judgmental way in which they praised and encouraged their attempts to deal with their children with behavior problems. This positive, supportive and non-critical approach from the leaders appears to have played an important role in the groups, helping to establish a trusting and supportive atmosphere between leaders and parents and among the parents themselves. One mother described the importance of being met with a positive and non-judgmental attitude by group leaders, which helped her to reduce guilt feelings and feel that she had the potential to become a better parent.

> "It's very important to be met in a positive way. I like the fact that the leaders did not criticize parents for being incompetent and told us that we hadn't done the wrong thing with our children. Before the program you feel that you can't control your own child and you can't handle him right, and then you start the training and hear that what you have done was not wrong. You read the book and go to the course and find out that you acted correctly under the circumstances, but that you can improve things and maybe do things in a slightly different way that works better. I think it was fantastic to feel that we weren't being judged for the things we did. When you are criticized for the way you raise your child it really affects you personally, because you are the one who brought them into the world and raised them, and you always feel guilty when things don't go well with them. There's a lot of guilt, I'm the one who is responsible for them. Parents feel guilt and responsibility when it goes poorly with their child. I have a bad conscience when I get angry at them for doing something wrong, so a guilty conscience hangs over you like a dark cloud the whole time".

Another mother described the role of the group leaders in establishing a positive group atmosphere, and in helping the parents to increase their self-confidence about their abilities as a parent.

> "There was never any boring or unnecessary information. Everything was arranged in an interesting and exciting way and you learned something new each time. I couldn't wait to tell my friends what we had learned. Our group was really close-knit. And it really made a difference that the leaders were such terrific people, they were really

> tops. Even though they might have seen that one of the parents had behaved very badly with their child, they still made that parent feel that they had done their best, and that they hadn't done anything wrong. You felt so meaningful, and that you had done a great job with your kids. They made us feel proud. It gave me a good feeling that I hadn't felt before. I used to feel like a bad mother who couldn't manage to get my child to function normally. They treated us with respect and understanding. I think it's very important that the leaders had the warmth and the compassion that they had. You can't sit there all arrogant without being able to empathize with the parents' situation. We were certainly very lucky to get those two leaders. It's not just anyone that can stand there and lecture in that way, because you accept it in a totally different way if you have respect".

Another couple especially appreciated the personal attention and caring attitude of the group leaders along with praise and encouragement of their parenting efforts. This motivated them to try even harder to improve their parenting skills.

> "The teachers we had in our group were totally amazing, great people. People-oriented and they really cared. You felt that they really cared about you personally. And I think it was comforting to know that if you were having a bad day, that that was allowed, it was okay. We could discuss anything with them… They contacted us at work too, called between course meetings to hear how things were going. And if you felt you had done something right and told them about it you would always get a lot of praise and that was so good. So they were very, very good at motivating you to continue being a good parent. That was good… They remembered what we talked about on the telephone if we had told about a situation. They thought it was very good to hear about and could talk about it on the phone, and they remembered it 3 or 4 days later when we came to the course so we could talk about it together in the group. They would say 'that was really interesting what happened to you, tell the group about it'. So we could talk about it, and it was so good that they remembered it. So you felt that they really cared because they listened to what you had to say. I think they were so likable".

What parenting skills did parents learn and how did they work?

The main goal of the Webster-Stratton program is to teach parents better ways of raising their children, which are intended to improve their child's behavior. Parents differed a lot in their descriptions of whether and how the program had improved their

parenting skills. Most of the parents seemed to have understood the program's basic message about positive parenting, and to pay more attention to and encourage the child's positive behavior, while ignoring as much as possible their negative behavior. Most parents did feel that they had learned new parenting skills during the program, but they varied considerably as to how specifically they described these skills, and what results, if any, they felt they had achieved.

Some parents talked in relatively vague terms about understanding their child better, knowing better how to deal with various situations, and getting new tools they could draw upon as needed in the future. Others were more specific about techniques they had learned and situations where they had used them. Parents seemed to have greatest success with methods related to encouraging and rewarding the child's positive behavior. These included paying more attention to the child, playing with them one-to-one, giving frequent praise, and giving tangible rewards if the child achieved specific goals, like doing homework or going to bed on time. Other parents talked about reducing constant scolding and replacing stricter methods of punishment with ignoring, time-outs, and withholding privileges. Several parents talked about using the methods not only with the child who was the target of the training program but also with other siblings, or even their spouse. Some parents seemed to have achieved the best results by paying more attention to the child and focusing upon and rewarding positive behavior. Some parents who began using this approach described rapid improvements in the child's behavior, as was the case for this family.

> "The program was a real gift for us. I got my life back. Before the program, everything was a struggle, my life, the children. Afterwards I could enjoy myself again and see the joy of having children. I was so tired and discouraged; I don't know what I could have done. The difference between before and after the program was really unbelievable. I've learned to be consistent and set limits all the time. We have to have established routines. He's very dependent on eating, drinking and sleeping. I have to keep a close eye on him or he can get very restless, angry and irritating. That's true of everyone, but especially him. I have to give him the right food and not too much sweets. I spend a lot of time with both children, so I don't think he gets special treatment. I try to do things with both of them, give them a lot of love, attention, and care. Ignoring bad behavior doesn't work with him. It works better to have a quiet talk with him and make eye contact. I don't use ignoring anymore, but I do use stickers, for instance if he does his homework or sits quietly at mealtime. Then he manages to live up to it. Praise, rewards, and love are the thing for him. If there's something we're struggling with, we sit down and talk about it and set up some rules. We agree to work together, and then he really focuses on the

> stickers and looks forward to a reward. He responds best when we give him praise. He still resists if we criticize him, which happens sometimes; then it's on with the boxing gloves. I use praise on purpose to get results, it takes so little. Stickers work best when I use them infrequently. It's easier to discuss with him now then before. He can apologize and show respect which is also new... I think that if I continued to focus on the negative like before and got worn out; I wouldn't have managed to follow up with him. Now he's learned to be more respectful, and to have empathy, and to understand consequences. I would never have been able to focus on empathy and getting him to understand consequences without the program".

Another mother saw a quick improvement in her son's behavior after she stopped scolding him all the time and began to pay more attention to him, and particularly to the things he did right.

> "The most useful thing about the program for me was learning ways to handle X, which made our daily life much easier for everyone. It was praise, and giving positive feedback, and giving him your full attention, and not just sitting and reading the newspaper when he asks a question. You look him in the eyes and repeat some of what he says so that he understands that you're interested, so he doesn't need to get my attention in a negative way. We started at once. I've always said that I'm willing to try anything, and he needed help to get along better. We saw how quick things turned around, and that just whetted our appetite. It works! But it was very difficult in the beginning to change our habits, especially when I was tired, then it's easy to just yell at him, you know what I mean? But there was gradually less and less shouting and it turned into more positive things. I've learned a lot from that. I was tired before and didn't know the right answers, how easy it is to turn things around. When you're exhausted and don't have any hope, and everything is terrible, and you are negative yourself then you don't have anything positive to give".

Some parents learned individual techniques which they tried to apply without making use of other aspects of the program. This type of approach tended to be less effective than using the new methods more holistically. This mother talked about trying to ignore the child's negative behavior, but made no mention of encouraging positive behavior. They felt this was effective initially, but difficult to continue with after the program ended.

> "It helps what we learned. I spent a week visiting my mother with both children, and it was a real test of my patience. I tried ignoring our younger child when she asks for something. I say no, and she says I

want it. I tried to learn not to say no, just to ignore her. I try very hard, but she doesn't give up, but I've been strong and managed to ignore her sometimes, but that drives other people around me crazy. 'Aren't you planning to answer your child?' So I've tried explaining to my parents that it's called ignoring and we're supposed to do it like this, and then they understood. But you get tired of listening to her sometimes, and after a while you just want to turn to her and shout 'No!' but I restrained myself. We also used sitting on a chair in the corner, time-out. We used it a lot when we were learning it, and it was effective. But we haven't used it that much afterwards. I think sometimes we should have used it more, that's what we've been laziest about... It was obvious after the program was over that things went backwards. It's easier for adults to remember the things we've learned earlier but for children it's not that easy. They are very dependent upon the parents following up afterwards and continue to implement the project. Sometimes we forget too. I don't think we're the only ones with that problem. I've seen some of the other parents in the store or somewhere like that without them realizing that I've seen them. I've seen how they shout at their child. So there are others who have forgotten a lot too, both children and adults".

Keeping up the new methods after the program ended was a problem for a number of the parents. It was easier for parents to try out new techniques while they had the support of the parent group and the leaders.

"The best thing about the parent group was talking to the others, I guess. Trying out different methods, we tried using a reward system and ignoring and things like that, but it didn't help very much. I wasn't able to keep it up over a longer period. We used the reward system for quite a while, but she realized herself that she couldn't manage it. It worked at first. I started with giving stickers for toilet-training. If she managed to keep herself dry and clean for a whole day then she would get a sticker. After she got five stickers we would go some place like the swimming pool. It worked a little at first, but when she made a mistake she would just give up. I tried to talk to her and tell her that she had to keep trying, but it wasn't the same, so we just stopped after a while. We tried ignoring bad behavior too, and that worked sometimes, but it depends how I was feeling and what kind of mood I was in myself. When I'm a little tired it wasn't always that easy. I think it was okay to have tried the new methods though... Well you know the methods helped a little bit, there were some small changes for a while, but then things went slowly back to the old pattern".

A few parents were more pessimistic and found it difficult to follow through on the new methods with their child. It was one thing to learn the methods during training and quite another to carry them out at home with the child.

> "The most useful for me with the parent group was talking about it (her situation), actually, and seeing that others struggled a little more than me... I think there was a lot we learned that was difficult to carry out at home, because it's one thing sitting and talking about it, and another to carry through with it. Not everything worked equally well. I tried, but things didn't always go well. In the beginning it worked with stickers (as reward for good behavior), that worked well. But I feel it has to seep in gradually, so it's difficult to say what worked very well and less well. I think overall that a lot of it was difficult to carry out at home. I had to think so much about how I did things myself, and of course when you are worn out yourself, when you are already struggling, it's very easy to give in... I tried to finish the homework assignments, but I didn't always finish everything. 'I'm not saying I didn't make an effort, though".

Parents' impressions of other aspects of the training program

Parents gave their opinions of various other aspects of the program including the children's groups, filling out questionnaires for research purposes, and their views on different teaching methods employed by the group leaders including group discussion, role play, video clips, and homework assignments.

Learning methods - group discussions, role play, video clips and homework

Presentation of the Webster-Stratton Parent Training program in the parent groups is done through a combination of teaching methods which feature mainly the use of video vignettes, role play, group discussions, and homework assignments that are presented at the group meetings. Parents were asked about their reactions to these teaching methods used during the parent group sessions. Parents had mixed reactions to these approaches. Group discussions with the other parents were, for many parents, the most useful aspect of the training groups. Group discussions gave parents a welcome opportunity to share experiences with other parents and to exchange useful advice about parenting methods.

> "We had a really good chemistry in our group. In a way we were divided in two because there were two couples that were older than the others who had more experience with raising children. We would trade seats after we got to know each other better, and we really had a good time. We laughed; it was a very humorous group. We weren't silent and thinking 'do I dare to say this, will I be embarrassed, never'. We said things openly whether we agreed with each other or not, and that was really great. We learned an unbelievable amount from each other. Parents would say, 'we tried this and that and it worked for us, maybe you should try it too.' We gave each other a lot of good advice, and a lot of it really worked. Like ignoring bad behavior, I think that was what worked the best".

> "I think it was a really positive group, we talked about a lot... We could sit there and talk, and there were several that had the same type of problem with their children, and we could discuss experiences, and get advice from each other about how to handle things. A lot of it is things you already know, but it helps to hear it from other parents. We wrote the advice on the blackboard and made copies which I've saved in my folder. We take them out sometimes still and review them".

Time constraints limited the time available for group discussions which some parents wanted more of. The program for each session was planned in advance and specific topics were intended to be covered each week. Each topic was presented in part through the use of video clips depicting various situations involving interaction between parents and children with behavior problems. Some parents felt that the program was too intensive and recommended spreading the program out over a longer period.

> "We were frightened in the beginning to open up with strangers, but by the end we had too little time. We wanted to talk more and more about our personal experiences, but the program could sometimes be quite general. We weren't supposed to directly discuss our own children, but rather to talk in terms of possible situations. We didn't have enough time, but we did have personal discussions afterwards with two of the couples... We grew closer to the other group members after a while and talked more privately during the breaks. There was not enough time during the course itself to exchange experiences with the other parents because the group leaders had a program they had to get through. We discussed more during the breaks. We are still in contact with two of the other couples, and they are also very satisfied with the whole program. It's been useful getting to know parents of children with behavior problems who we feel we can contact in the future to discuss things".

Parents had more varied reactions to the other types of learning techniques. Role play was generally the learning method which was least popular. Some parents, particularly fathers, were skeptical to the use of role play. Some found it to be intimidating because they were shy and didn't like having to perform in this way in front of others in the group. Some found it to be artificial and not a useful way of learning the new methods. Some found it difficult playing the role of a child. Other parents did like the role play which they said added an element of humor, helped to break the ice, and to stimulate discussions.

Parents also had mixed reactions to the video vignettes. Some found these to be useful in illustrating the program concepts by providing visual examples of different types of interaction between parents and children in more or less familiar situations. Others felt that the videos were not relevant enough for current Norwegian reality because they were outdated, and filmed with American parents and children, and then dubbed to Norwegian. Some felt that the situations depicted were artificial or too obvious, and that it was too easy to see what parents should have done differently in these episodes.

> "The video clips were okay, but they were a little old-fashioned. That's what we reacted to I remember, that they were filmed a long time ago, the clothes and things like that. They were alright, but sometimes they really didn't help that much. Maybe one or two of them really taught me something new, but a lot of them were not very interesting".

Some suggested using less time for videos or role play and more time for group discussions about real problems and situations they had encountered.

> "The least useful part of the parent groups was the role play. I didn't like those. Sometimes I had to participate, but I always sat there and hoped I wouldn't get picked. Some of them were good, but some were really stupid. Like when we were supposed to play the role of a child, and I thought 'Hello!' what does this have to do with anything'. It was no fun playing a child when you are home with them every day and the same thing happens each time... I'm not sure what I think about the video vignettes. I think it's so dumb to focus on an example with one child and one situation because children are so different and they react so differently. You can't compare the situations in the videos to our child. I've always been opposed to that kind of filming because it's so artificial. The parents know they are being filmed so they make an extra effort, and that's not right. Reality is not like what we saw in the videos... It would have been more useful to discuss the situations that happened to us at home, and to have heard from the other parents

> if they had advice for us about that particular situation. There was very little of that. I think that would have been more useful than the video clips. We did talk to each other about situations at home during the breaks, but they were only ten minutes long. I'm not sure if the other parents would agree, maybe some of them liked the videos".

Another mother had a similar suggestion.

> "I think the program was mostly positive. The role play was a little - 'was this really necessary?' But it was okay, we got some training, and it was really just common sense... Everything was useful. The video clips were useful to illustrate an example but we didn't have to watch five clips that showed the same thing. Some of the parents reacted to the videos - 'we are adults, we get the point, it's enough now'. It would have been better with a little less time spent on the video clips and a little more time to talk to each other and tell about situations from our daily lives - a little less time on video and little more time on real life".

Most parents were positive to the homework assignments they were expected to complete for each session. An example mentioned by several parents, was to play with their child for 10 - 15 minutes each day at some activity chosen by the child. They found the homework to be a useful way to practice the new skills they were taught during the course. Some appreciated the praise they received from the group leaders when they reported on the progress they had made with their child. Others found it difficult to find time to complete the homework on top of a busy schedule with work, the children, and other household responsibilities. Some found it hard to practice the assigned exercises with the problem child, because of the need to relate to brothers and sisters at the same time. Some tried to solve this problem by practicing the new methods with all of their children. One couple liked the homework assignments best; found the video clips to be a waste of time, and the role play to be a little better than they had feared.

> "The video clips were boring. They were a little outdated and not very stimulating. They seemed like they were from the 1960s, and they were very artificial. I thought the role play sounded really silly too, but it wasn't that bad. It helped you to be more aware of what you did and didn't do, and what you said. I think they were fun. They were a little scary too. You could make a fool of yourself in public, improvising in front of a lot of people you don't know. But the role play helped to loosen up the atmosphere in the group. It made it easier to talk. It added a little humor too... The most useful for us with the groups were the homework assignments. We would practice one thing at a time, like playing with him. Now I don't play with him anymore, never. I've thought about it, but I just don't have the time. Also giving praise

> for different things, I think that was really useful. So I've become really good at praising him after that, also trying to ignore the negative".

Not all found it easy to follow through on the homework assignments or to cooperate with a partner on carrying these out.

> "The homework assignments were a little stressful. We have a busy life. It's a little less hectic now because the children are getting older. We tried our best to do the homework because we realized we had to do it if we were going to be in the program. We didn't always agree about what needed to be done, there are two of us after all. But it's actually okay too, because it presses you to think a little about things. It was demanding but it was okay".

Dinosaur school (children's groups)

During the Webster-Stratton clinical trial in Trondheim and Tromsø, parents were randomly assigned to three different groups for comparison purposes - a group which received Parent Training only, a group which combined treatment consisting of both Parent Training and dinosaur school for children, and a group which was initially assigned to the waiting list (all were later offered participation in the program). Families in our study were evenly divided between those receiving only Parent Training and those with the combined treatment. We did not interview any of the children directly, and have, therefore, only limited and second-hand information from half of the parents about their children's perception of Dinosaur school.

Not all parents seemed to have understood or received adequate information about how families were assigned to the two treatment groups. Not all were aware that assignment was done randomly for research evaluation purposes to enable comparison of results between the two treatment groups (and a control group). Parents whose children did not participate in dinosaur school seemed generally disappointed by this, and some stated clearly that they had wanted the child to attend Dinosaur school.

Parents whose children participated in dinosaur school were satisfied with this part of the program, and felt that the children were also satisfied. Some talked about useful skills the children had learned from these groups including how to control their tempers, and how to play with and empathize with other children in the group. Children were generally proud of their participation in the group and some bragged about it to siblings, relatives and classmates. These parents talked about how much their daughter had gotten out of dinosaur school.

> “She really enjoyed going to dinosaur school. She got support and help and really had a good time. She made a lot of new friends. We were lucky that we got to be in both the parent group and dinosaur school because I don’t think we would have gotten as much benefit as we did from just going to Parent Training. It’s not just that she enjoyed it there, but we both feel that she really grew unbelievably much during the time she was there. Every time we came to pick her up there she was just smiling from ear to ear - ‘see what I got’. It was stickers and that sort of thing. She really took part, she didn’t just sit there and watch; she answered and participated. She really liked the puppets and the way it was designed for children. She asked us after it was over when we were going to go to the program again. She always took out the puppets they gave her and the book and she liked to read it. It seemed like she wanted to continue. She was a little sad when it was over, she cried... One of the things we liked about dinosaur school was that they encouraged the children that were shy like our daughter. She needed a lot of praise and feeling that she belonged. She still does. That school was really good for her”.

Another mother said:

> “I think the dinosaur school was good. X told us a little about it, how they had to count to three before they reacted and lots of things like that. He managed to make the other kids in the neighborhood jealous. He felt grown up and got praise when he learned to be patient and not get angry. He was proud of himself, and other parents asked us how their children could get into dinosaur school”.

Filling out of questionnaires

Parents were required to fill out comprehensive questionnaires about their child and the family’s overall situation several times during the course of the program. These were required for research purposes and are not part of the Parent Training program itself. Parents, and particularly fathers, almost all found these to be both time consuming and unpleasant. They did it mainly because it was expected in return for their participation in the training program. A few were also glad that they could help contribute to research on an important topic that could benefit other families. Some parents also reacted to the personal nature of the questions, despite the fact that the results were confidential. Some parents also reacted to the fact that some of the questions were inappropriate for a child of that age.

> “I thought it was a lot to read, a lot of pages. It took awhile before I felt like filling out all the forms. It took a lot of time to answer all the questions. I understand that they want it to be thorough, but there were

> a lot of questions that weren't really about Norway at all, more about America. There were questions about murder and really serious things that weren't relevant for us. They should have screened out those sorts of questions. It was partly because they covered such a wide age range. They asked about break-ins and robbery and alcohol and drug abuse which we don't think about at all with such a young child. So they really should have cut out those types of questions. It was a waste of time to sit and answer those questions that had nothing to do with our situation".

Another mother said:

> "We thought it was a lot of bother filling out all the forms. In many families these days both parents are working, and a lot of them don't realize that the questionnaires can be important for the ones who sent them. They can be set aside and forgotten. Like for us, I've been busy, so I've sat with them in the evening. Each evening I've filled out several pages and then I have to go to bed. Then it's a new day with new challenges and the children need to be taken care of. There just hasn't been enough time for it, so it becomes something you are forced to do. But it shouldn't be like that, it should be natural to answer the questions. But I have done it just to be finished with it, and that's what's been most negative".

Chapter 4 - Parents' Views of the Situation after Parent Training

Parents were interviewed for this study in October - November 2003 which was approximately 18 - 24 months after they had completed Parent Training. The final portion of the interview focused on their views of how things had gone with them and their child after completing the program. They were also asked about their thoughts on the child's future. Had they seen changes in their child's behavior which they felt could be attributed to their participation in the program, and if so how stable were these changes over time? What help had they received with their child in the year and a half to two years after the program and what help did they feel they would need in the future? How did they think that things would go with their child in the future? They were also asked if they had any suggestions about how the Parent Training program might be improved.

Parents' views of the situation for their child and themselves at the time of the interview varied considerably, as did their thoughts about the future. Some parents described noticeable improvements in their interaction with their child, and in the child's behavior, which in some cases also continued in the period following the program. These parents not surprisingly, often tended, to be more optimistic about their child's future, and to feel less need for continued help after the program. Other parents were far less optimistic. Though they may have benefited from the program and from meeting other parents in a similar situation, they described little improvement in their child's behavior. They tended to be more pessimistic about the child's future and wanted more help after the program. Some described temporary improvements in the child's behavior which were difficult to maintain after the program ended and the family returned to their familiar patterns of interaction.

It is worth noting, however, that the variation we found in parents' views about changes in the child's behavior is at least partly due to the method of sample selection. One of the criteria used to select parents for our interviews was the mother's perception of changes in the child's behavior before and after participation in the Webster-Stratton program. Parents were selected so as to ensure variation in their perception of

such behavior changes ranging from worsened behavior, to little or no change, to significant improvements.[3]

Many of the parents expressed concern about what would happen to their child as he or she grew older, especially as they entered puberty and faced the increased risks and challenges of adolescence. Some were aware of research describing increased risk of problems later in life for children with serious behavior problems in early childhood. Some of the parents felt that they had been left too much on their own after the program ended. They talked about the need for a follow-up course, and about wanting to maintain contact with other parents in the group. Some of the groups did get together informally after the program ended.

Parents who saw improvements in their child's behavior tended to be more optimistic about the future

Some parents described improvements in their child's behavior after participating in the Webster-Stratton program. They attributed the changes, at least in part, to what they had learned during the program. They were more optimistic about the child's future than they had been previously. Some anticipated no need for additional help with the child. An example of this was a mother who had struggled with her son's anger and aggressive behavior for several years at home and at preschool before starting the program. They learned to play with him and give him more positive attention, and his behavior quickly started to improve. The improvements continued after the program, leaving the mother more optimistic about the future.

> "We still struggled with X after starting the program, but quickly started to see changes after we started playing with him for ten minutes each day. Before, he used to poop in his pants when things went against him. We soon saw how important it was to play with him and give him our attention. He was very hungry for attention; it was surprising how important this was...There's been a big change in his behavior after we finished the program. He started laughing at things in a way he never did before, and got his sense of humor back. He stopped hitting. He still fights with his brother, but that's just a sibling thing. He's gotten a lot of feedback from school that things are going well there. There are never any episodes at school, he's liked by eve-

[3] Mothers' rating of changes in child behavior was done as part of the clinical treatment trial using a standardized assessment instrument called the Eyberg Child Behavior Inventory (ECBI). The ECBI asks the parent to rate the frequency of 36 types of problem behavior, such as quarrelling with siblings or refusing to go to bed on time.

ryone and has lots of friends... We have learned a lot from the program which we use when we want to make changes in their behavior. It's made me aware that the time they spend with mother and father is important. X has blossomed and thrives in the neighborhood, at school and in his whole life. He's in good humor and shines like a sun from the moment he wakes up. But he's still sensitive, he's a vulnerable type. He had a loose tooth for 3 months before he dared to have it pulled out. He's a little cautious; he's the most cautious one in the family. He has friends on the street, and makes new friends easily. Life is easy for him now... We don't see the need for any more special help with him. If he's allowed to be a little boy and build up his self-confidence even more then he'll turn into a confident young person and a confident adult".

Another mother described progress with her son who had been angry and dissatisfied and didn't fit in at preschool. His behavior started to improve rapidly after they started the program and continued afterwards. She is optimistic about his future.

"He blossomed quickly after I started the program, but he's a tough little nut to crack and I still have to hold the reins on him all the time, I can't relax... I saw early on that it helped to give him praise and attention. He was calmer and happier. It became easier to talk to him after a while. It didn't happen immediately, but he started to understand more, and I understood better how he felt. Then I could accept it more easily if he was angry one day, and I knew better what to do so that he would calm down. You learn more about yourself and how to tackle things differently. It was really good to know that you weren't alone with it, but had the support of the program... We work better together now. He's gotten better at asking me about things first, not just going ahead and doing them, so we avoid a lot of conflicts. He'll ask me - Is it okay, Mom? And I just think wow, is that my child talking like that. He's really changed a lot on all levels, and also at school. Now when I go to visit people he behaves perfectly. I hear - my goodness, how he's changed, and then I realize that I like to get praise too... The program was really a gift. I got my life back. Before the program, everything was really tiring, life, the children. Now, I can enjoy myself again, and feel the joy of having children. I was always tired and things felt hopeless. I didn't know what to do. I thought he'll be six years old soon and I still don't know how to handle him. The difference between before and after the program was unbelievable...I still need cooperation from his school. We have regular contact, and if anything happens they call me right away, and if anything happens at home I contact them, so they know that now X is going through a difficult period. I have to have that contact... As long as the school and I continue to follow up with him, I don't think there will be any prob-

lems. He’s on the same level as all the other normal children. He’s really bright and has a lot of positive qualities. As long as he is able to use them in the right way I see a bright future for him”.

Some parents were concerned about the future despite improvements in the child's behavior

Not all parents who had seen improvements in their child’s behavior were equally optimistic about the future. Some worried about what would happen as the child grew older and faced increasing challenges at school and elsewhere. Negative prognoses for children with ADHD worried some of these parents. The parents below were concerned about how things would go with their son’s temper when he became a teenager, despite the progress he had made during the program.

> “There’s been a big change in his behavior from the time we started the program until now. That’s due at least in part to the program (the son was in dinosaur school too) and everything he’s gone through there. We’ve also become a little better at dealing with him, but he’s also matured and things have fallen more into place for him. Things have really turned around for him at school; he’s become a model pupil... He has a very strong temperament which I hope he can learn to control because otherwise it will be a bigger problem for him later on. He can get really angry, and then he can kick and hit anybody. He’s not totally out of control, but he’s not far from it. He gets angry especially if he feels that something is unfair. His big brother especially can get him to totally explode... If he loses control in different situations and doesn’t outgrow his temper it will be a problem. He’s improved, but he still has room to get better. We don’t need help with this immediately, but if he still has violent temper tantrums when he becomes 12 or 13 or 14, then he’ll really be able to hurt someone and we’ll have to do something more about it. When he was at his worst I’d sit with him and hold him so he wouldn’t destroy things. He broke a little chair one time. He cried and cried, and I thought now I can manage to hold you, but when you get bigger I won’t be able to manage, and what will happen then? But I think it will be alright. But I can’t always manage to think positively, especially if I’m tired and things are tough. Then I’ve thought that he’ll surely be like the guy we read about in the newspaper who killed someone when he was out of control. You think the worst when you are really depressed. Mostly, I think things will go okay. I think he will be able to use his temperament in a positive way and it will be a source of motivation for him”.

Another mother had seen big improvements in her son's behavior after the program. They continue to receive help in the form of extra resources at school and a "big brother (personal aid)" four hours per week. She is concerned about what will happen when her son becomes a teenager, especially because he has been diagnosed with ADHD.

> "We have gotten a more positive life. I feel I have more energy. X used to be in a bad mood and some days I felt like he was a big brat. It was difficult to sit down with him for ten minutes and play with him. But now he's so positive and happy, even though he's still very dominating, so I just sit down with him and let him lead the activity. I just stay with him so that he knows I'm interested in him. Now he does his homework before I get home. Before he sat there for hours and struggled, threw his books and tore the paper in pieces. It's been an unbelievable change... Right now things are going smoothly, but if we have problems again I'm not afraid to contact the leaders from the program... Just yesterday I read on the internet about ADHD about how 80% of the young criminals in prison had that diagnosis, and then I was worried. I also worry about what will happen when he gets his driver's license if he gets angry in the middle of traffic. Things like that worry me. But I don't doubt that he will be a good person. He has so many good qualities. I hope that he will get enough schooling and be able to get a job. I'm not that worried about it unless he gets tempted by excitement and crime and comes together with other young people who don't get their medicine and who smoke hashish or use other drugs. What I'm very worried about is what will happen when he reaches his late teens. I think other parents worry about that too, even those whose children don't have ADHD".

Parents who did not see improvement in child's behavior were often more pessimistic about the future

Some parents did not see much improvement in their child's behavior during or after the program. They tended to be more pessimistic about their children's futures. These parents were also concerned about how things would go with their child as they grew up and faced increasing challenges at school, as teenagers, and in finding a job. Many of these parents wanted additional help when the program was over. The parents in the example below were concerned about their child who had a learning disability.

> "We became more conscious of giving praise, and that made him happier, but it didn't really change his behavior that much. It's difficult being consistent about setting limits; we tend to spoil him. He ran off

> from school with two other children and we gave him house arrest for a week... The most important thing was getting his diagnosis of brain damage, after the program was over. He has concentration problems and difficulty reading. We learned what was really wrong with him and found out that it didn't help to yell at him all the time for not trying. The last period has been tough mentally for us and I have felt tired out... We're apprehensive about what will happen when he starts junior high school and may be bullied. If he feels that he's not good enough he may wind up with a bad group of kids like alcohol and drug abusers, and just drop out. It's really important that we follow him up closely and know where he is at all times. We're worried about his temperament. I think - what if he becomes a violent criminal. It's important that he gets tasks which he feels that he can master and that he finishes school and finds a job he likes. His dream is to operate a bulldozer. That would be great if he can manage that".

These parents have a child with Tourette syndrome who they feel improved a little after the program, mostly because he became older and calmer. They are concerned about his future as his school work becomes more difficult, and as he is exposed to the temptations of the teenage years.

> "His school work will be more of a challenge in the future. I'm a bit pessimistic; I look forward to and at the same time dread what will happen when he gets bigger writing assignments. He's never enjoyed doing homework; it's been really up and down, tiring. He often protests if you try to help him... So we have a big challenge, because he needs to be challenged, but he has his limitations too. There are certain things he can't manage that don't function as well as for other children. But we also try to avoid creating too many barriers for him. He needs to be able to do the things he wants... It seems like he has good judgment, and is a good judge of character, he's quite mature in that way. But you can't be sure how things will go. We're worried about what happens when he becomes a teenager. Then a lot will happen in his head, and how will that affect him? It happens to everyone, but it can be worse for him because of Tourette syndrome. His hormones will change in puberty, and what will happen then when he is exposed to alcohol and other things? It affects everyone. How will it affect him? There are lots of things like that we think about. I'm a bit worried about it, but I am still hopeful because he's not usually so unpredictable".

Many parents felt the need for more help after the program

Though parents were generally satisfied with the Webster-Stratton program, particularly with the support they got from meeting other parents in a similar situation, many felt that the 12-week training program was not enough. This was particularly the case for parents who were concerned about the future. They felt the need for continuing help and support after the program was over. Some parents wanted a follow-up course arranged by the child psychiatry unit. Almost all the children had started school by the time of our interviews, and some parents wanted more help from school in dealing with the child's problems. Many wanted to maintain contact with other parents they were together with in the training group, and a number of the groups did meet socially after the program had ended. These contacts were difficult to maintain over time and tended to become less and less frequent. Some parents continued to search for more information about what was wrong with their child, including the mother below who wanted more help with her child after the program ended. She and her daughter got help from school counseling services before being admitted to a short-term family therapy program.

> "Parent Training was not enough, we needed more help. We had to go further with it, it wasn't enough. I couldn't manage it all by myself. I told them at the child psychiatry center that I needed more help. So they referred us to the family therapy unit, but we had to wait at least a year to get in. In the meantime, we got a little help from school counseling services. They advised the teachers about how to handle her at school... We were at the family therapy unit for four weeks. We lived there and she went to school there with to special educators. They observed her at school to see how far she had come academically. There were also family therapists living in the house with us who helped with practical things and had conversations with us during the day. It was very comprehensive and quite exhausting... I still need more follow-up help with her. Lots of times I can't see that she's falling back to the old problems; it's easier for others to see that and to give me a warning. I hope the school can help us and apply for extra resources for her... Which thoughts do I have about her future? On my darkest days I see her as a juvenile delinquent; I have to admit that. She could wind up in a gang that uses alcohol and drugs and that sort of thing. I've heard that it is children who are very insecure about themselves who end up in that kind of gang. But on the other hand, I think no, we're going to manage this. It's going to be okay... The last year I've been mostly pessimistic. It's been very tiring. Last winter I was really down, I thought things would never get better. I told my mother once I

> just want to lie down and pull the covers over my head and just stay there. But at the same time, I have this little instinct that you shouldn't give up, so I keep on trying. But there's been very little positive this past year".

Some wanted treatment for the child after the program, like this mother who worried about her daughter's anger and her strained relations to her divorced father.

> "I think she could use a psychologist. It's not that she's strange, but she thinks a lot about things and doesn't say very much. I'd like to have some outside person talk to her who could get her to open up a little. About what she's thinking about, and why she gets so angry. When she comes back from visiting her father and his mother she's very angry for a couple of days. I don't want to blame them, but what is she thinking about? It's not that easy for her being caught between me and her father. She probably has a lot of questions. Why can't I visit there more often, aren't I good enough for him?"

Another mother continued to search for an answer to what was wrong with her son. He too struggled with the conflict between his parents who were divorced.

> "I don't get any special help with X after the program. I'd like to get him assessed to find out if he has any disease like ADHD. My sister-in-law said things were better for them after her child was diagnosed (with ADHD) and they found out that he was sick and not just a difficult kid. That's why I'd like to get him assessed. It would be easier to deal with his father too if they found something wrong. I dread every other Sunday when my son comes home after visiting his father... If I find out that X has a mental illness then I'd like to be in a support group with other parents in the same situation. If there's any medicine he could take to make his daily life easier I wouldn't turn that down either".

Some parents wanted a combination of different kinds of help after the program, like this family, that wanted both special education services, financial aid, and help with their son's motor skills. They felt that they had not received good enough information about what help they were entitled to.

> "He will still need special education services at school like those he's getting now. It would be better if he could get more hours a week, but his school doesn't have enough resources for that. We just got financial assistance to help cover our extra expenses because of his disability. I learned about this from another family, but we hadn't received information about this earlier. The social services office wondered

> why we hadn't applied for this earlier, but we didn't know about it earlier. They should have told us about it at the program. We've also applied for a portable computer for him to help with his learning problems. You have to find out about all these things yourself, because nobody gives you information about your rights. I'm only working four days a week, and I just found out at the social service office that I may be able to get paid for staying at home to take care of him".

Some parents need help with baby-sitting after the program so that they can get some time for themselves away from the child. These parents have had trouble finding someone to take care of their daughter.

> "We don't get much time for ourselves because it's hard finding others who know how to take care of our children. It just causes more problems afterwards. Their uncle is one of the few people who can manage them, but we're afraid to ask him too often".

Many of the parents felt that the program was too short and too intense. They were sad when the program ended, and wanted to continue both to learn the parenting methods and to keep in touch with other parents in the group. Some of the groups did meet socially after the program ended, but such contacts were difficult to maintain over time. One mother wished the program could have lasted longer.

> "I think it was very sad when the program ended. I wanted to continue with it, but I realize that's not possible. New parents need to be given the chance to get the training too. It's up to the parents too what they do about it, like calling each other on the telephone or meeting".

Some parents found the program too short and too intense and wanted a follow-up course to help refresh what they had learned, as shown in the three examples below.

> "One thing that could have been done differently that we talked about in the group was that it got a little intense, a little too much at one time. It's clear that there was a lot of information to digest, and very much to do in a short amount of time, that was the impression a lot of us had. It would have been better to spread the program out over a longer period".

> "It would have been better if we could have started the program earlier when he was younger, and if it lasted longer. It was a great program, so if it lasted longer we would have learned even more. There should be a follow-up course. It was a lot in a short period. You need more time to try out what you've learned. There was not enough time for

each topic. We didn't know enough when the program was over, so we had to start again, which I wasn't expecting".

"We would have liked a follow-up course after a year or two. Children grow and change and even if we're not having as much trouble as before, there are still things we could use help with. We wanted the program to last longer; we were really busy trying to cover everything in just 12 weeks, with two topics each time. We wanted a little more time and more follow-up. I have the names of the others in the group, but you don't think about doing it in the course of a hectic daily life. We would have liked it if the program had invited the group to a follow-up course. It could be spread over several weeks without having to meet each week. It could be more intensive in the beginning, with longer intervals between meetings later on. That would give us more time to try things out".

This mother wanted both a follow-up course and continuing contact with other mothers in the group.

"Our group discussed during the program that it would be good if we could have a follow-up session a half year after the program ended. It could be more often than that, for instance every other month. We've noticed that we've been very lazy about following up the methods we learned. It's hard to remember everything and think about it all. It would help to refresh what we learned, and to hear how the other parents in the group are doing. I know we are not the only ones who've been lazy about using the methods, because I've talked to some of the others in the group afterwards... The mothers in the group have gotten together after the program a couple of times. We were home to one of the mothers for a ladies evening. We had a little to drink, and discussed and had a good time. There was a lot of laughter. We exchanged stories and there was a lot of interesting stuff. Not everyone has come each time, but we've had three get-togethers. It's a while since the last time. I don't know what's happened; it just seems to have been forgotten. We talked about meeting again at our last gathering, but it's hard to organize it. It would really be good to get together again".

Some parents wanted help from the program to keep up contact with other parents.

"I wish the program had made a little more effort to ensure that parents should maintain contact with each other after the program, and privately during the program. We benefited so much from the contact".

Some groups were able to meet on their own, but it grew harder to keep up contact as time passed.

> "We've had contact with the other parents once in a while during the first year after the program. We had decided to meet once a year, we'll see. We met once last year with parents and children for a barbecue which was great fun. It's interesting to see how things have gone with the others, if they have stagnated or made progress. We weren't that close friends so it's not surprising that we've drifted apart. We have each others' telephone numbers".

> "We had great contact with the others in the group. We've grown apart now, because it was the program that held us together. We knew then that we would meet each week, but we lost contact with each other when the course was over".

Parents' suggestions for improving the program

Parents were generally satisfied with the program and had relatively few specific suggestions for improvement. Some parents wanted more time for discussion with other parents about their experiences with their children, and less time spent on videos and role play. As noted above, some thought the program was too short and too intensive and recommended some form of follow-up so that they could maintain contact with other parents in the group and refresh the skills they had learned in the program.

Some parents felt that it should be easier to find out about the program, and recommended that information be made available to parents at places like preschool and public health clinics. Some felt that the program should be available for all parents, and not just parents of children with behavior problems. Some thought it was important that both the parents and the child be given training and one thought that the child's siblings also should be offered a chance to talk with other siblings. Some thought the program would be better if parents did not have to fill out all the questionnaires for research purposes.

Chapter 5 - Discussion and Conclusions

Before treatment: Demoralized parents who have not gotten sufficient help

In this report we have been concerned with parents' experience of living with and raising a child with severe behavior problems before, during and after their participation in Webster-Stratton Parent Training. Parents described the heavy burden of bringing up a child with these types of problems, and the very real consequences this has had for themselves, the child, siblings and other members of their extended families. Parents were frustrated, demoralized, resigned and filled with feelings of responsibility and guilt, because they had been unable to handle their child more effectively. They felt stigmatized by neighbors, professionals, relatives and others who blamed them for their child's poor behavior. Though they had received various types of help from community services including preschool, advice and counseling, and special education services, none had received sufficient help to identify the real nature of the child's problems, or to manage the child's behavior more effectively. Parent training was a clear turning point for many of these parents which gave them a kind of systematic assistance which was not otherwise available from these community service providers.

The interview subjects were parents of young children with very serious levels of behavioral disturbance. These parents, like others participating in the clinical treatment trial, were selected for treatment based on their descriptions of their children's behavior problems on a screening instrument used for this purpose - the Eyberg Child Behavior Inventory (ECBI) and from a diagnostic interview. It is, therefore, not surprising that parents' descriptions of their children's behavior before treatment generally correspond to the description of symptoms specified for ODD and CD, including anger and aggressive behavior, uncontrolled and directed at parents, siblings and other children, high levels of activity and restlessness, poor concentration and a need for constant supervision, defiance and disobedience, and apparent inability to follow even the simplest instructions. It is worth noting, however, that parents interviewed present a slightly different account of the child's behavior affects them, than that which is embodied in the DSM-IV diagnostic criteria, or the ECBI. Oppositional behavior was troublesome for parents whom we interviewed, but not as troublesome as aggression, uncontrolled and very restless or overactive behavior, among these predominantly ODD-diagnosed children. What is possible is that parental concern, stress and man-

agement problems among Norwegian parents may focus more upon uncontrolled behavior and aggression, than on non-compliance. Whether this reflects some specifically cultural attitudes and norms, is an interesting question.

Like similarly affected parents in other countries whose situation has been studied, they have felt the impact of their children's behavior in many ways (Webster-Stratton and Spitzer, 1996). The accounts by parents that this report summarizes and exemplifies, give an indication of the burden and misfortune that a seriously disturbed child represents for his or her family. We see that family functioning and coherence are seriously threatened. Families of children with such severe difficulties as those treated in the program in Trondheim and Tromsø, have very considerable needs and are in fact at serious risk. Managing the child, and daily life in the family, very rapidly becomes difficult and exhausting. Parents described situations in which the child's behavior invariably became worse. Nothing that parents attempted could arrest this deterioration. Parents struggled with feelings of guilt, responsibility and inadequacy. They felt trapped, frustrated, exhausted and as time went on, often resigned. Their relationship with the child became "gridlocked": there was a negative cycle of unacceptable behavior, and ineffective parental responses. Parents felt stigmatized and isolated by relatives, neighbors, friends and community service personnel who blamed them for the child's poor behavior and for maintaining inadequate parental control.

In our material too, there any many signs of the "ripple effects" described by Webster-Stratton and Spitzer (1996). There is no respite, and family life and relationships in the family including the relationship between mother and father may be threatened. This puts additional strain on everyone concerned. Disruption and frustration escalate. Mothers and fathers often disagreed about how to deal with the situation, and their relationship suffered in a number of cases. There are also instances of siblings being adversely affected. Some parents said that it was impossible to give a sister or brother of the affected child enough attention. Other siblings were given too much responsibility for their age and were expected to help take care of the problem sibling. Siblings were often the target of the disturbed child's anger and aggression and quarreling and fighting between siblings was not uncommon. Relations with grandparents and other relatives were also often difficult and the child's behavior often was embarrassing, which in time led to withdrawal and isolation. It was difficult to make visits or receive visitors.

Parents told us that they were usually the first to see these problems, sometimes in very early childhood and almost always by the time the child was 3 - 4 years old. Parents were often unsure about what the problems actually were and about what to do

with them. This uncertainty lasted a long time, and in most cases was not resolved until the family entered Parent Training. Preschool staff played the key role for most families in identifying and confirming behavior that was problematic and abnormal, and to some extent providing an explanation of the children's difficulties. These difficulties often became more apparent after changes affecting the family, as for example when a child started at preschool (kindergarten), or the birth of a younger sister or brother, or the parents separating. This in some cases might have led parents to think that their child was reacting temporarily to circumstances or stress.

It might be thought that parents underestimate the scale of the problems that gradually affect their children, and seek advice too late. Although some reservations have to be made in interpreting retrospective accounts, it does not seem that this played any part in the histories of the children in our study. Parents realized that something was wrong early on, and sought advice, but they were confused as well as alarmed. Naturally enough, and as parents often do, they blamed themselves or wondered whether they were managing the child's behavior properly. Some looked for an answer to their questions and sought help. But little help could be obtained. There is no evidence here that informal support, network resources or relatives can provide really useful help. Parents become increasingly isolated as the children's problems escalate. They need expert help.

Community health, social and educational services have not been able to help these parents very effectively. They have not had structured programs that might provide a framework for managing the children's behavior, and they have lacked the expertise or authority to define the problems affecting the child. The material we have obtained makes it clear that these parents affected by children's very severe problems, often experience very real concern on the part of community service professionals and preschool staff in particular. Service professionals care enough, but usually have not anything substantial to offer. Parents did receive some help including preschool for the child, advice and counseling, and other support services including special education services and temporary care-takers for the child such as weekend placements. But this help was largely insufficient, and some parents complained about unsympathetic or misguided helpers who were unwilling or unable to provide parents with needed services.

Early Intervention: Preschool as a missed opportunity?

At the end of chapter one, we indicated that accessibility is a key issue in evaluation of services which set out to help families deal with children's problems. The Norwegian Webster-Stratton program included special efforts made to make it easy to refer children to the clinics offering the program. But recruitment of children to the treatment trial was at times difficult (Tjelflaat et al., 2002). There are clearly various thresholds and barriers that limit access to help for children with behavioral difficulties, especially when they are very young. Specialist health services like child psychiatry are probably less accessible anyway, since they can only be accessed by means of formal referral. Parents may see referral to child psychiatry as an alarming prospect.

When asked about the help they had received before entering Parent Training, most parents singled out preschool. All the children in the sample had attended preschool and most parents were satisfied with the attention they and their child had received from preschool staff. Other contacts that had been useful for some parents were community health services, school including special education help, and school counseling. Some parents actively sought help to obtain a diagnosis or explanation of the child's difficulties. A few parents were dissatisfied with the help they were provided with, or dissatisfied because they had not obtained help when they wanted it. (This dissatisfaction may well be less widespread in the parents in our sample, than in parents with behaviorally disturbed children in the 4 - 8 age range in general, since they had all entered the training program after referral, often with the help of community service staff). Child protection and school counseling services were the main referral agents (about half of the families), while preschool and the community health services each provided only about one-fifth of the referrals. Some parents had taken the initiative themselves, and sought help from the program, after obtaining information about it from the media or from friends.

So preschool is the best support for these parents, to judge by their own accounts, but preschool does not refer many children. The more specialized community services, particularly school counseling and child protection channel most referrals. It might be expected that health center nursing staff who have periodic contact with all small children in Norway would be another important source of referrals, but this was the case for only a few of the parents interviewed for our study. The health service personnel do not meet the children concerned very often, and may not always be aware of parents' concerns about the child's behavior. It is easy to see the importance of preschool in the light of the fact that children attend on a daily basis, so that their behavior prob-

lems are hard to miss. There seems to be some reluctance on the part of preschool staff to refer directly, and this is understandable in view of the fact that they often hesitate to draw conclusions or make strong recommendations to parents. Preschool is provided with its own community service specialists in the form of child protection and school counseling. This referral route no doubt takes time, and may partly explain why it proved difficult to recruit many children younger than six years, during the treatment trial (Tjelflaat et al., 2002).

Preschool is a lost opportunity for referral to Parent Training for many families. Parents get a lot of useful support from preschool staff, but most of the children in our material spent two or even three years in preschool before they were referred, or were not referred while in preschool. Those who were referred or whose parents contacted the clinic themselves (children under six) were fortunate. There was a training program available. They might well in many cases have spent their early years in primary school too in a steadily worsening cycle of disruptive behavior and increasing isolation, before their behavior placed such a strain on those around them that they were referred. This, after all, has been the usual career for many of even the most severely disturbed children.

There are quite clear indications in the interview material that parents and preschool teachers have agreed that the children's behavior was alarming and abnormal. A possible explanation for the very considerable numbers of children with pervasive behavioral difficulties that were treated in the program is this congruence between parents' and preschool- and schoolteachers' views of the children concerned. [4]This has, in effect, reinforced parents' concern. If this is so, it serves to emphasize even more the crucial significance of preschool in implementing strategies for early intervention in this field.

The lapse of time between the first signs of serious behavioral disturbance, and referral, was often several years or more. Most of the children are in preschool for most of this period, and much valuable time would be saved if preschool, in co-operation with parents, was able to refer directly, or was better supported by other agencies, so that referral could be discussed with parents at an earlier stage. There is no doubt that preschool teachers do become aware of these serious behavioral disturbances, even if they feel unable to draw definite conclusions about the problem, and that the situation usually is discussed parents. Some parents do not feel it is right to assent to referral to

4 Over 80% of the children admitted to the program, had behavioral difficulties at clinical levels at home *and* at preschool/school (Larsson and Mørch, 2004).

child psychiatry when a child is very young, and this has to be respected. But it is difficult to avoid the impression that preschool is the key to early referral, the more so because many parents seem to have confidence in the staff there.

We have relatively little material in this study that can throw much light on how the more specialized community services, including school counseling and child protection, deal with behaviorally disturbed children who are causing concern. Though some parents did mention that they had been in contact with these agencies, this was usually not described in much detail. These agencies provide support to preschool and schools and in some cases directly to parents through observation of children's behavior, advice and counseling, and assistance in obtaining extra resources such as special education personnel. These agencies have also played an important role in referring parents to the Parent Training Program. They were involved in referring half of the parents interviewed to this program.

The material also illustrates the formidable difficulties that are encountered in getting help. Presumably better access to treatment of various kinds, due to implementation of the various methods being deployed in Norway now, ought to lead to considerable improvements. But we should surely not simply assume that access will improve. Since a great majority of Norwegian children attend preschool, the findings of the present study seem significant. Few children were referred for Parent Training at preschool age and few directly from preschool (only one-fifth of the families we interviewed). As the Webster-Stratton program has now established itself as a permanent program in Trondheim, the proportion of children under age six who are referred to the program has risen, but most of the children are still referred from community services for children and young people, and most are still of school age. Since parents (with a few exceptions) seem to have most confidence in preschool staff, and indeed seem to have perceived the help provided by them as the most useful, it would appear that the best potential platform for dialogue with parents, early referral and early intervention, is preschool. But this platform is unlikely to materialize without deliberate effort.

It is of course important that schools also are aware of the seriousness of the risks associated with behavioral disturbances, since some children develop symptoms later than others. Our material can only give an indication of the age of onset (and it is really far too restricted to give a proper estimate), but it is interesting to note that all of the parents we interviewed told us that worrying symptoms had appeared before their child had started school. Schools were directly involved in referring about one-sixth of the families in our study to Parent Training, and were likely also involved in some of the referrals where school counseling played the leading role.

Our findings about the period before treatment suggest that much work needs to be done to lower referral thresholds for children in the target group. Child psychiatric services are perhaps more often than we care to admit, seen as intimidating and alarming. Some of the parents we interviewed had been skeptical of child psychiatry before starting Parent Training, and some believed these services were only for families with more serious problems. Referral routes from community services are slow. The community health services and preschool are the most important arenas for early identification of children who need help. Much work needs to be done to create a proper framework for identifying children with severe behavioral disturbances, as early as possible.

Treatment: the key role of the parent group

Our material describes a form of treatment which almost always realizes some (if not all) of its major aims. The group setting provides parents with a considerable boost in terms of self-esteem and confidence, and understanding of their situation. This effect is long-lasting, and it was clearly evident when we interviewed them, 18 - 24 months after treatment. Parents also to a very great extent seem to have absorbed certain basic principles such as the importance of positive reinforcement, avoiding negative parenting and harsh discipline. More questionable, however, is the extent to which parents were able to learn and consistently make use of the parenting methods presented during the program, and whether these helped them to achieve behavioral improvements in their children. A majority of parents did tell us about new techniques they had learned and used, and some also talked about improvements they had seen in their child's behavior. Other parents were more uncertain or equivocal on these issues, including what techniques they had actually learned, whether they were able to use these effectively, and to what extent they continued to use them after training was concluded.

Parents also differed greatly with regard to whether or not they had seen improvements in their child's behavior after participating in Parent Training. While some did see clear improvement, other parents reported little or no changes in this regard. Some parents saw short-term improvements which were difficult to maintain after they no longer attended Parent Training. This finding is not unexpected, in light of the way

parents were selected for our interviews, as discussed in the first chapter, this was one of the criteria we used to select the sample of parents interviewed.[5]

But these findings must necessarily lead to other questions about the effectiveness of treatment. After all, parents whose children responded very poorly, or not at all, to treatment, also seem to have experienced most if not all of the beneficial effects of Parent Training mentioned here. One of the most impressive things about the treatment is, indeed, that it boosts morale for parents whose children do not respond well. How does this happen?

Parents' own view of the matter is that meeting others who share the same difficulties as themselves is very important. They feel understood, and much less isolated, and feelings of guilt and inadequacy are reduced. Interaction with other parents in the group provides parents with several important benefits including mutual support, increased self-esteem, a chance to discuss their problems and experiences with others who understand what they are going through, and the recognition that their problems are not unique or abnormal. In an important sense, the therapeutic relationship as parents experience it, resides in the common experience and mutual identification of the parent group.

This finding is consistent with previous experience from group work with different types of client groups in different settings. The importance of the group process as a means of promoting mutual support and improving self-esteem among group members with similar psycho-social problems has been recognized for years by social workers and other therapists involved in group work with client groups. Heap summarizes this process as follows:

> "In brief, the group process is shown as commencing with a particular type of group composition, characterized by close similarity of psycho-social *needs and problems* on the part of the members. In social work and related fields such problems will usually subject members to *stress*. In groups which are composed in this way, where the *size* of the group is appropriately determined, and where the group has suffi-

5 Mothers' ratings of children's behavior before and after parent training on the Eyberg Child Behavior Inventory (ECBI) were used to select parents for our study. We deliberately included relatively equal proportions of mothers reporting little or no improvement in child behavior, moderate improvement, and greater improvement. This likely resulted in a higher proportion of families with children showing little behavioural improvement in our study, as compared to the treatment trial group as a whole. On average, mothers' ECBI ratings for the intensity of their children's problems decreased by 34 points for the treatment trial group as a whole, reflecting a significant improvement in behavior, on average (Larsson and Mørch, 2004).

> cient *time* available for its objectives, interaction will occur. That interaction will lead to *discovery of commonality* and thus to a degree of *mutual identification.* The resulting *group bond* or '*we-feeling'* is the source of members' ability to give each other *support*, to exert *mutual control*, to facilitate *recognition* of both hidden feelings and strengths, to alleviate feelings of isolation and deviance by *generalization* and to enable more successful self-representation through *collective power.* These qualities are the resources of the group. To 'use group process' is another way of saying that we seek to generate and mobilize these qualities in groups (Heap, 1985, p.15)".

Heap's description matches closely what parents told us about the dynamics of the Parent Training groups. Similar findings have been made in other studies of parent training, including Webster-Stratton Parent Training in the United States. Like the parents in our study, the Webster-Stratton and Spitzer study stressed the importance of the parent group as a means of providing mutual support and for reducing the stigma parents had experienced.

> "All the parents we interviewed talked about the importance of the parent training group and the tremendous support that the group had given them. Just knowing that other parents had children who were also challenging and difficult to manage helped to 'normalize' their problem, to take away the stigma. Hearing those parents week-by-week struggles with their children's behavior helped defuse their guilt, anger, and frustration… In general parents seemed to derive the most support from other parents who openly acknowledged the difficulties of parenting and were nonjudgmental (Webster-Stratton and Spitzer, 1996, p. 53)".

Studies of other types of parent training programs have also shown the importance of meeting other parents who are confronting similar problems. An evaluation of the Family Links Nurturing Program in the United Kingdom for use in the treatment and prevention of child abuse and neglect had similar findings. That study emphasized parents' satisfaction with the parent groups which provided a source of mutual support, reassurance through the recognition that other parents have similar problems, reduction in guilt feelings, and support for their role as parents without criticism of their current parenting practices (Barlow and Stewart-Brown, 2001).

As in other research dealing with successful therapeutic settings and relationships, we see that the mechanics of the helping process are not really the main focus for clients. Group leaders are, like therapists or social workers in other research work where client perceptions have been studied, seen as persons with valuable and admirable *personal*

attributes, including warmth, enthusiasm, humor, and concern for the clients (Uggerhøj, 1995). Some parents also stressed the importance of group leaders who were supportive, uncritical, and nonjudgmental. These leaders modeled the positive, supportive and encouraging approach that parents were taught to use with their children. This approach together with the positive interaction with other parents combined to increase parents' self-esteem and reduce their feelings of guilt and self-doubt. But the morale booster, in parent's view, is certainly not only or even principally in the relationship with the helpers. It comes from the mutual recognition and identification the parents experience in interaction with each other through the group process. The group leaders contribute to this mainly by creating a positive and supportive group atmosphere, and by helping to facilitate a constructive interaction between group members.

A majority of parents said that they used the techniques taught in the program (some apparently did so with some considerable success) but some did not use them much if at all. Some parents reported most success with techniques aimed at recognizing and encouraging the child's positive behavior such as playing with the child, paying more attention, use of praise, and rewards or incentives for certain types of activity. Some parents provided detailed accounts of the improvements they observed in their child's behavior after starting to use these methods. Some of those who said they did use the techniques provided diffuse and equivocal descriptions that do not resolve the issue of whether the techniques were being applied regularly or with any consistency, or how well these parents really understood the new methods. On the whole, the balance is tilted toward some kind of association between use of techniques and behavioral progress by the children, but this finding is rather ambiguous. We have to conclude that many parents do learn techniques, and do apply them, but that Parent Training in this setting does not fully realize its aims. Not all parents use the techniques, and the extent to which they are applied is in many cases rather uncertain. Some parents felt able to use only some of the techniques, while others found the techniques difficult to apply once the support provided by the program and the group, no longer was available.

A question that can be asked is whether the improvements obtained are in the main due to perceptual changes on the part of parents, and increased insight leading to greater tolerance of their children's behavior, or whether they reflect the continued application of methods and practical devices that the program teaches. Or indeed, whether both of these factors influence the results of treatment. In other words, we can ask whether changes in the children's behavior are involved, or whether improved morale and perceptual changes on the part of parents are the main mechanism involved in producing the favorable results. This is a complex issue, and our findings suggest that the answer varies from family to family. Parents who feel better about themselves and

about their own competence as parents may well see their child in a more positive light, even if the child's behavior has not changed that much. Many parents also gained greater understanding of their child's behavior, which at least in some cases seems to have increased their tolerance for difficult behavior because they have become more aware of why the child is acting the way he does.

A more objective assessment of what changes have actually taken place in parenting practices and/or child behavior, though clearly relevant, is not possible within the constraints of the present study which is based solely on parents' subjective experience of these matters. The treatment trial study does have some information on children's behavior as reported by teachers at school and at preschool, before and after treatment. Results from that study indicate that while preschool teachers report substantial behavior improvements, teachers of school age children report only limited improvement. Most of the children in the treatment trial were of school age (Larsson and Mørch, 2004).

Mixed views about the actual devices used in Parent Training also seem to imply that the actual mechanics of group training are not the main issue. Parents have very varied views about homework, role play and video vignettes, but their views about these devices have little to do with their overall perception of the value of the treatment or its relevance for their situation. Some parents found role play to be artificial and intimidating and preferred not to participate. Some found the video clips to be outdated, artificial, and not relevant for current Norwegian reality. Some parents also reacted to dubbing from American to Norwegian which sometimes had a comic effect. Other parents found these learning devices more useful, and an effective means of illustrating parenting principles or for stimulating group discussion. Parents sometimes felt that there was not enough time for discussion between parents, and that the group leaders were too concerned with pushing things along to ensure that the planned topics were covered at each session. Some found the sessions to be too intense and thought that there ought to have been more sessions, spread out over a longer period of time.

If we look at these findings in the light of the requirements that we specified at the end of chapter one for a successful family preservation program, our conclusions are as follows:

1. *The treatment should have elements that appeal to parents and are motivating for them.* On this point, the interviews on the whole show a positive result. Evidently, the parents who entered the program had a degree of motivation, since they agreed to referral and decided to enter the program. Once the sessions be-

gan, it seems that almost all the parents we interviewed rapidly became integrated in their group. They looked forward to the sessions and were highly motivated to attend. The program in Trondheim had very good attendance at sessions and almost no dropout. As we have seen, identification with the parent group and the generally very positive impression the group leaders gave, were important elements that reinforced motivation. Perhaps the most important factor of all was the sheer relief all parents experienced, in meeting others who had to deal with the same problems as themselves.

Some aspects of Parent Training had only partial appeal, and here we refer first and foremost to the actual devices used in sessions such as role play and video presentations. Many parents also disliked filling out multiple questionnaires about their child and themselves which were required for research purposes by the treatment trial study. Group discussion was what parents wanted, and of course the desirability of more such discussion from parents' point of view, serves to emphasize the central significance of the group as a motivating and supportive factor. Some parents thought that sessions were rather pressured, with a too crowded agenda, leaving too little time for discussion.

2. *The treatment should give parents an understanding of their child's difficulties and of their own role and choices in respect of these.* The broad conclusion must be that Parent Training succeeded in these respects. Almost all parents appear to have absorbed the message relating to positive parenting practices. A number of the interviews, where parents describe the situation at the time of interview, reveal considerable reflection relating to the child's difficulties, their progress or non-progress, and various issues relating to the parents' role and their management of the child. The influence of the Parent Training content is quite evident, also in cases where the child's progress after treatment has not been particularly good. It has to be emphasized that not all parents are equally articulate in these areas, but the general impression is clear enough. Some parents (usually mothers) complained that their partners or spouses did not provide support or make adequate efforts to understand their child's difficulties or to carry out the techniques presented during Parent Training.

3. *The treatment should provide specific solutions to the real, everyday problems that children and parents encounter*. Here again the general impression is that the requirement has been fulfilled. Parents usually relate this to the way in which the group as a whole included parents in the same situation as themselves. They felt that they were *understood* and that they received useful advice about techniques that had worked for other parents. There were some interviews in which parents showed their appreciation of group leaders who displayed concern and recognition of the efforts they were making at home, in the everyday context. Some said that group leaders "modeled" the behavior and approach that they themselves were encouraged to adopt with their children.

4. *The approach should contribute to a strong and close relationship between the parent and the child.* Here the impression we have is much more diffuse and variable. There are certainly a number of clear indications that Parent Training in some cases has been succeeded by a phase in which parents establish or re-establish a warmer, more intimate relation to their child, in some cases accompanied by development of a dialogue. Some parents talked about being able to enjoy their child again after years of strained relations. They talked about children who were happier and easier to talk to, and who responded well to parents' increased attention and praise. But relations with the child have not improved much if at all in some of the families. Some parents reported continued conflicts and a high level of family tension also after Parent Training. Some parents experienced temporary periods of better contact with the child, which proved hard to maintain after the training program ended and the family was left to their own resources.

5. *The approach used should be comprehensible seen from parents' viewpoint.* There can be little doubt that the approach to children and the concepts applied in the treatment are communicated to parents. Most parents seem to have understood the main message of the program - positive parenting - and the importance of recognizing, encouraging and rewarding positive behavior and ignoring or deemphasizing negative and provocative behavior. While parents varied in their capacity to utilize these methods effectively, this was generally not due to their lack of understanding of basic program principles.

6. *It should not involve techniques or approaches that are too difficult or demanding for parents.* Program results in this regard are more variable. The Parent Training program does place considerable demands on parents. They are expected to attend and participate actively at weekly training sessions, to practice the new methods at home between sessions, to report on their home experiences, and to continue to employ the new techniques on their own after the program is over. While parents generally seem to have tried their best to fulfill these objectives, not all were able to master the new techniques or to apply them consistently and effectively with their children. Some parents found it more difficult to apply techniques, after the support provided by the group and the leaders was no longer available. A few seem to have been discouraged because the child showed little improvement. On the whole, parents' ability to apply the approach they were taught is variable, and this an area in which the program is only partly successful.

After treatment

Interviews with parents included questions about their current situation (18 - 24 months after they completed Parent Training). What is most striking about the families' situations after the training program is that they vary a good deal, with some par-

ents being quite optimistic, while others are worried about the future. Parents who felt that their children's behavior had improved after training, not surprisingly, tended to be more optimistic about the future. Many parents though reasonably optimistic about the near future, expressed concerns about how things would go with their child when they became teenagers and faced a whole new set of challenges in that connection. Some parents were also concerned about research findings portraying negative prognoses for small children with serious behavior problems which they read about.

The treatment trial results showed that average ECBI scores that had improved markedly during treatment more or less maintained their lower levels in the post to follow-up period, but that no further improvement took place in averaged scores and that treatment reduces stress levels in parents, and this reduction is maintained (Larsson and Mørch, 2004). Webster-Stratton's qualitative follow-up study showed that parents still had to deal with a very difficult situation after treatment, with continual effort being needed to manage the behavior of the affected child (Webster-Stratton and Spitzer, 1996).

The conclusion from our interviews is that parents are on the whole less vulnerable and have more control over their situation than before treatment, but that they *still are vulnerable.* Most parents seem to have been able to maintain the improved morale and better self-esteem which they experienced during the Parent Training. One very real gain which is evident in some of the interviews is that parents are able to reflect upon the child's needs and use the insights acquired in the program. Despite this, many parents feel that they still need ongoing support. While some families have managed to improve relations with relatives, neighbors and the community, may continue to feel isolated and feel a need for additional help. Many parents have made some effort to keep in contact with parents who were members of their group, but these contacts have proved difficult to maintain as time has passed. Some parents want help from child psychiatry in renewing these contacts and some want follow-up training at regular intervals. Some parents also want additional support from community services, particularly from schools and school counseling in order to assure the child extra attention at school. It is clear that a few of the families, at the time of interview, had difficulties with the behavior of more than one of their children, and some form of structured follow-up would have been useful in this connection too.

Conclusion

The 19 sets of parents who have generously allowed us to ask them about the challenging situation they have faced in raising a child with serious behavior problems have provided an honest, fascinating and detailed account of what this experience has been like for them, their children with behavior problems, and the rest of their families. Parents have also provided a thoughtful assessment of a twelve week treatment program, Webster-Stratton Parent Training, and their views on how and if this program has been able to help them and their child. Perhaps the most important conclusion of this study is that while these families all share a common challenge, they are nonetheless very different. Each family had its own story to tell, and while there are clearly important similarities, there are also fundamental differences and variation which are inevitably lost when a researcher attempts to summarize and draw conclusions from such a rich and complicated material.

With this in mind, some conclusions which may be drawn from this study include the following:

1. *Parents were generally the first to become aware of their child's problems and usually while the child was 3 - 4 years of age or earlier.* Parents were most concerned about children's anger and aggressive behavior and about hyperactivity and restless, uncontrolled behavior. Parents were often unsure about the real nature of the problems or what to do about them.

2. *Raising a young child with serious behavior problems placed serious burdens on parents and other family members, especially siblings.* These children were often the main focus of their families and helped create a difficult atmosphere which had negative consequences for all family members. Parents blamed themselves for their inability to handle the child more effectively, and often became frustrated, angry, tired, and resigned. Families were often stigmatized by relatives, neighbors, and others in the community and tended to become isolated.

3. *Most families were in contact with various community services before starting Parent Training but these were unable to provide parents with the type of systematic assistance which they needed to raise their children more appropriately.* Preschool provided useful help for many families, but mostly for the child and as relief to parents who were no longer alone with the child all day. Health services and school counseling also helped some families but did not teach parents better approaches for raising their children.

4. *Most families had to wait several years or more before they were referred to Parent Training, during which time the child's problems often became more serious.* School counseling and child protection referred most children to Parent Training, but this usually did not happen until after the family and others had struggled with the problems over several years. Health clinics and preschool teachers often had relatively early knowledge of the problem, but usually did not refer families directly to the program. Some parents took the initiative to apply for the program themselves without help from community services. These findings indicate that some families could clearly benefit from a more active effort on the part of health clinics, preschools, and other services in early contact with the child to inform parents about the Parent Training program and to help those interested to apply for the program.

5. *Nearly all parents were very satisfied with Parent Training and particularly with the support and encouragement they received from other parents in the group.* Discussions with other parents in the parent groups was the most positive aspect of the program for most parents, including those who did not feel that they had improved their parenting skills or seen significant improvements in their child's behavior. The parent groups provided an important source of mutual support and helped them to recognize that they were not alone with this type of problem. The groups helped parents to increase their morale and their self-esteem, and were a forum where they could discuss problems and solutions with others who understood them. Parents felt less isolated and less guilty about their parental short-comings.

6. *Most parents understood the program's main message about positive parenting.* Parents learned the importance of paying more attention to the child's positive behavior and praising, encouraging and rewarding this type of behavior. Parents also learned to ignore negative behavior and to avoid frequent scolding and harsh punishment.

7. *Parents were positive about the role of the group leaders, but more skeptical about some of the teaching methods used, particularly the use of video clips and role play.* Parents were most favorable to the group leaders' personal characteristics including their enthusiasm, warmth, supportiveness, concern for the parents, and non-judgmental attitudes. Some parents were also satisfied with the teaching methods used, but some were more skeptical to role play which they found to be artificial and intimidating, and to American video clips which some found to be old-fashioned and not relevant for Norwegian conditions. Many parents wanted more time for discussions with other parents about their experiences and about successful child raising strategies.

8. *Parents varied considerably in their ability to consistently and effectively use the new methods they were taught.* While some parents said they were able to apply the new methods with their children and to use these to improve the children's behavior, others were much more uncertain about what they had ac-

tually learned, and found it difficult to use them consistently with their children. Some parents said it was more difficult to practice the new techniques after the training was over.

9. *Some parents did not report improvement in their child's behavior after Parent Training.* While many parents did report considerable improvement in their child's behavior before and after Parent Training, this was not the case for all parents. (This may partly be explained by the criteria used to select parents for the interviews). Parents who saw improvement tended to attribute this, at least partly, to the new techniques they had learned and used, but other factors were also cited including the child's natural maturation. More information is needed about families who were not helped by parent-training in order to determine whether this is due to the way the methods were taught, to some parents' inability to learn and use the methods, to their inappropriateness for some children and their problems, or to other factors including the family's overall situation.

10. *Parents varied considerably in their views about the future.* Some parents were basically optimistic about their child's future and about their ability to meet future challenges which might arise. These parents felt that they now had improved parenting techniques which they could draw upon as needed. Parents who had seen improvements in their child's behavior also tended to be more optimistic about the future. Some parents were more pessimistic, and these were often concerned about what would happen to their child when they became a teenager facing the increased risks and temptations of this period.

11. *Many parents wanted some form of follow-up help after Parent Training.* Many parents, including those who were basically optimistic about the future, expressed the desire for follow-up help. Many parents were sad when the parent groups ended and wanted to maintain contact with other parents in the group. Some groups did have some contact after the training ended but this was difficult to maintain over longer periods without support from child psychiatry. Some parents also wanted additional Parent Training, either a new course or follow-up sessions to refresh what they had learned at regular intervals. Some parents expressed the need for continued support from other community services particularly school, school counseling, and special education. It is unreasonable to expect that all families will be self-sufficient after a 12-week training program, so some form of organized follow-up for all families attending this program would seem to be a wise investment.

12. *Webster-Stratton Parent Training is a beneficial form of help for many parents of young children affected by severe behavior problems.* The information provided by these 19 sets of parents indicates that the parent training they have received was a positive and beneficial form of help for many of them. Most parents liked the help they received and felt that it was right for them. Most said they would recommend the program to other parents in a similar situation,

and some have suggested that the program should be offered preventively to all first time parents. Parents largely accept the basic lessons about how to approach and manage their child. The mutual support which the parents provide to one another under the guidance of positive and enthusiastic group leaders goes a long way toward increasing parents' self-confidence and to overcoming years of self-doubt and frustration. Some parents also feel that they have acquired improved parenting skills which they are able to use to interact more constructively with their children, and which has led to improvements in their child's behavior.

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Attachments

NTNU
Det medisinske fakultet
Institutt for nevromedisin og bevegelse
Regionsenter for barne- og ungdomspsykiatri

ALLFORSK
Barnevernets utviklingssenter
i Midt-Norge

Trondheim, september 2003

Til foreldre/foresatte

Jim Lurie, forsker
Tlf.: 73 59 62 71, Fax: 73 55 08 48
E-mail: Jim.Lurie@allforsk.ntnu.no

De utrolige årene: Delprosjekt 2 -Undersøkelse av foreldres opplevelse av å bo sammen med et barn med vanskelig atferd: Hvordan har det gått med barn og foreldre før, under og etter familiens deltagelse i Webster-Stratton programmet?

Det medisinske fakultet, NTNU og Barnevernets utviklingssenter i Midt-Norge skal gjennomføre en undersøkelse med noen foreldre som har deltatt i Webster-Stratton program ved BUP-klinikken i Trondheim. Hensikten med undersøkelsen er å finne ut mer om foreldres opplevelse av hvordan det har vært å bo sammen med et barn med vanskelig atferd over tid, og hvordan foreldre og barn har opplevd hjelpen de har fått gjennom Webster-Stratton programmet eller på andre måter.

Undersøkelsen skal fokusere på situasjonen til barn og foreldre i tre perioder- fra tidspunktet foreldre først ble oppmerksom på barnets vanskelige atferd og inntil de ble henvist til Webster-Stratton program, perioden de fikk behandling (foreldregrupper og eventuelt dinosaurusskolen) på BUP-klinikken, og perioden etter familien ble ferdig med behandlingen. Vi håper gjennom denne undersøkelsen å få viktig kunnskap både om hvordan foreldre har opplevd og taklet tilværelsen før barnets problemer ble tydelig identifisert og før de fikk tilbud om Webster-Stratton behandling, hvilke erfaringer de har hatt med behandlingsprogrammet, hvilke virkninger de mener programmet har hatt i ettertid, og i hvilken grad de har fått råd og hjelp i forbindelse med barnets atferd fra andre kilder.

Data skal samles inn gjennom et intervju med foreldre som vil vare i ca. 1,5-2 timer. Foreldre kan velge selv om intervjuet skal gjennomføres i hjemmet eller på kontoret. Intervjuet skal tas opp (med samtykke fra informanten). Det utbetales et honorar på kr. 500 per intervju til dere som deltar som informant.

Undersøkelsen er støttet av Helsedepartementet og Barne- og familiedepartementet og godkjent av Norges forskningsråd. Undersøkelsen er basert på anonymitet og opplysningene som dere gir vil bli behandlet strengt konfidensielt. Det er også satt opp begrensninger på rapportering fra denne undersøkelsen, slik at ingen vil kunne spore opp informasjon fra den enkelte familie. Dette gjelder også terapeutene ved BUP som har deltatt i behandlingsprogrammet. Prosedyre for innsamling og bearbeiding av data er godkjent av Forskningsetisk råd for Midt-Norge og Datatilsynet.

Vi ber dere om å lese og undertegne den vedlagte samtykkeerklæring. Den gir oss ved universitetet tillatelse til å bruke opplysningene som dere gir i forskningsøyemed. Tillatelsen som dere gir er avgrenset til dette bestemte prosjektet, og opplysningene som er samlet inn vil bli slettet når prosjektet er ferdig. Samtykkeerklæringen returneres til May Britt Drugli ved Regionsenter for barne- og ungdomspsykiatri eller Jim Lurie ved Barnevernets utviklingssenter i Midt-Norge. Om noe skulle være uklart, eller om det er spørsmål som knytter seg til intervjuene, kan dere kontakte forsker Jim Lurie, tlf. 73 59 62 71.

Vennlig hilsen

Graham Clifford
professor

Jim Lurie
forsker

Vedlegg:

Samtykkeerklæring - undersøkelse av foreldres opplevelse av å bo sammen med barn med vanskelig atferd

Jeg/vi har lest det tilsendte brevet om undersøkelsen av foreldres opplevelse av å bo sammen med barn med vanskelig atferd. Med dette gir jeg/vi min/vår samtykke til bruk av opplysningene i forskningsprosjektet, med de begrensninger som er omtalt i brevet.

(signatur)

Slippen returneres til Anne Mørkved i begynnelsen av intervjuet eller i posten til May Britt Drugli ved Regionsenter for barne- og ungdomspsykiatri/NTNU, MTF, 7489 Trondheim eller Jim Lurie ved Barnevernets utviklingssenter i Midt-Norge, Klostergt. 46/48, 7491 Trondheim

Barnevernets Utviklingssenter i Midt-Norge
Kasusundersøkelse
Høsten 2003

Foreldres opplevelse av å bo sammen med et barn med atferdsvansker:
Hvordan har det gått med barnet og foreldrene før, under og etter familiens deltagelse i Webster-Stratton programmet?

Innledning Data for undersøkelsen innhentes gjennom intervjuer med ca. 20 foreldre (eller foreldrepar) som har deltatt i Webster-Stratton programmet ved RBUP i Trondheim i perioden (?). Barna var i alderen 4-8 år og møtt programmets inntakskriteria i forhold til diagnostisert/målbar atferdsproblemer. Intervjuene brukes til å innhente foreldres beretninger om barnets atferdsvansker og deres livssituasjon i tre faser: før de begynt i Webster-Stratton programmet, erfaringer i behandlingsperioden, og erfaringer etter behandlingen ble avsluttet.

Utvalget for intervjuene er strategisk og har som hensikt å gi noe variasjon i forhold til barnas alder, kjønn, bosted, behandlingsform (foreldregrupper med eller uten Dinosaurus skole), behandlings resultat (har barnas atferdsproblemer blitt mindre), og eventuelt foreldrenes utdanningsnivå/inntekt.

Deltagelsen er frivillig og foreldre har anledning å ikke svare på noen spørsmål underveis. Intervjuene tas opp på band (med informantens samtykke). Foreldre kan velge intervjustedet – hjem eller på kontor ved BUS. Intervjuet er beregnet til ca. 90 minutter. Informantene betales kr. 500 for deltagelsen. (?)

Intervjuene er semistrukturert som betyr at intervjuguiden nedenfor brukes som ramme for å sikre at alle foreldre blir utspurt om temaene av interesse og at nødvendig opplysning innhentes fra alle. Guiden skal likevel ikke brukes for strukturert eller for kontrollerende – det ønskes at foreldre i størst mulig grad bruker egne ord og begrep og at de skal gi oss en skildring av prosessen de har vært gjennom, og sine egne vurderinger/erfaringer i forhold til dette. Under intervju med foreldrepar er det interessant å få frem eventuelle forskjeller i erfaringer/vurderinger dersom disse forekommer.

Intervjuguide

I. Bakgrunn informasjon

(dette informasjon kan kanskje innhentes fra andre instrumenter brukt av BUP)
1.Familiemedlemmenes alder og kjønn
2.Hvem bor sammen med barnet?
3.Hvem har daglig omsorg for barnet?
4.Boforhold
5.Foreldrenes arbeidsforhold, utdanningsnivå
6.Kort om situasjon til andre barn i familien – særlig om andre har hatt atferdsproblemer

II. Foreldrenes opplevelse av barnets situasjon før Webster-Stratton behandling ble initiert

1. Kan du/dere fortelle litt om ditt barn.
2. Når ble det klart for dere at det kunne være aktuelt med noen råd/hjelp i forbindelse med barnet?
3. Hva var det med barnets atferd som skapte bekymringer?
4. Kan du beskriver noen konkrete hendelser i denne forbindelse?
5. Hvis du/dere tenker tilbake, har det tidligere vært tegn som tydet på at han/hun hadde atferdsvansker?
6. Hvordan har barnets atferd endret seg over tid i perioden før dere begynt med Webster-Statton programmet?

(*ad. 1-6)* Foreldre må oppfordres til å gi en skildring av barnets utvikling siden fødselen, men sett fra deres sider, med deres begreper. Eventuelle sammenligninger med søsken, og beretning om faser/episoder som de selv legger vekt på er relevante opplysninger.

7. I hvilke situasjoner har barnets atferdsvansker kommet til uttrykk – for eksempel i familien, på barnehage/skole, med jevnaldrende osv.?
8. Hadde barnets oppførsel/atferdsvansker noen konsekvenser for familien deres? Eller konsekvenser for forholdet til andre (for eksempel slektninger, venner, naboer, skolen osv.)?
9. Er det andre enn dere som har uttrykt bekymring for barnets atferd, og i såfall hvem og når? Hvem først ga uttrykk for slike bekymringer?

(*ad 7-9)* Vi er interessert i hvilke problemer foreldre opplevd med barnet, og hvilke konsekvenser dette fikk for andre familiemedlemmer, for foreldrene selv. Få med om barnehage, skole og eventuelt andre instanser (helsestasjon) har tatt opp spørsmål angående barnet med foreldrene.

10. Har dere søkt eller fått råd om dette fra noen? Fra hvem, og i hvilken sammenheng?
11. Har barnet og eller dere som foreldre fått hjelp/spesialbehandling av noe slag før dere kom i kontakt med BUP-klinikken?
12. Hvordan forsøkt dere å handtere barnets atferdsproblemer før dere begynt på Webster-Stratton programmet?
13. Var dere fornøyd med hjelpen dere fikk i denne fasen?
14. Har familien vært i kontakt med hjelpetjeneste (Trondheim)/ barnevernet i denne fasen?

(*ad 10-14)* Fokuset her er spørsmålet om foreldre har søkt råd/hjelp og om de har fått dette, *før* spørsmålet om eventuell henvisning til Webster-Stratton behandling kom på tale. Hvilke råd/hjelp har familien eventuelt fått og hvordan har de opplevd hjelpen.

15. Hvordan fikk dere vite om Webster-Stratton tilbudet?
16. Hvordan kom dere i kontakt med BUP-klinikken?
17. Hvordan så dere på barne- og ungdomspsykiatrisk tjenester før dere begynt med Webster-Stratton programmet?
18. Tok dere selv initiativet eller var det noen bestemt person/instans som ga dere hjelp i denne forbindelse? I såfall hvem.

(*ad 15-17)* Måtte foreldre overtales til å ta kontakt med programmet eller var de interessert i utgangspunktet, hvem tok initiativet til kontakten?

III. Erfaringer fra Webster-Stratton program - henvisning og behandling

1. Hvordan var ditt/deres inntrykk av henvisnings- og utredningsprosessen som fant sted før behandling tok til?
2. Hvilket tilbud fikk dere fra Webster-Stratton programmet – foreldregruppe alene eller foreldregruppe pluss dinosaurusskole?
3. Hvordan var inntrykket av foreldregruppene når disse tok til? Ble inntrykkene/erfaringen annerledes etter hvert, eventuelt hvordan?
4. Hvilke helhetsinntrykk har du fra foreldregruppene?
5. Hva har vært mest nyttig for deg med foreldregruppen?
6. Hva har vært minst nyttig?
7. Er det noe som burde ha vært gjørt annerledes, i såfall hva?
8. Hvilke inntrykk har du av dinosaurusskole (dersom barnet var med på det)?
9. Hvordan opplevd barnet dette tilbudet?
10. Skjedde det noe endringer i barnets atferd i løpet av behandlingsperioden? I såfall hvilke endringer?
11. Fikk dere hjelp/råd fra andre instanser for dere eller barnet i løpet av behandlingsperioden? I såfall hvilken hjelp?
12. Ville du anbefale denne formen for hjelp til andre foreldre/barn i samme situasjon. Hvis ja, hvorfor? Hvilke negative sider ser du med denne formen for hjelp?

Kommentarer/sjekkliste
Her er det svært viktig at foreldrene får god tid og at vi ikke styrer intervjuet for mye. For å supplere spørsmålene, som foreldrene må først svare på uten for mye innblanding fra intervjueren, vises til sjekklisten nedenfor:

1. Eventuelle synspunkter på betydningen av intervjuer, spørreskemaer og tester utført før og etter behandling. Har dette vært greit, eller plagsom i en eller annen grad?
2. Synspunkter om formen og innholdet i gruppearbeid, terapeutenes bidrag, de andre deltakere. Synspunkter om videovignetter, rollespill, hjemmeoppgaver.
3. Inntrykk av de andre deltakere, om de har samme type problemer og erfaringer, om de har dratt fordel av hjelpen.
4. Praktiske anliggende: om det har vært greit å avsette tid til opplegget, til hjemmeoppgaver såvel som behandlingstimene, om tidspunktene er riktige og om barnepass osv har fungert tilfredsstillende.

IV. Etter behandlingen var gjennomført.

1. Hvordan har det gått med barnet og med andre familiemedlemmer (inklusiv dere som foreldre) i ettertiden? Hvordan går det med barnet hjemme og på skole/barnehage? Hvordan er barnets forhold til søsken og jevnaldrende?
2. Hvilke utbytte har dere som foreldre hatt av behandlingen? Kan du/dere beskrive hva dette går ut på? Hvordan gir dette seg utslag i hverdagen? Hva har dere lærte?
3. Har det vært noe endringer i samhandling mellom dere og barnet etter programmet? I såfall hva slags endringer?
4. Mottar dere noen form for hjelp eller spesialopplegg i forbindelse med barnet nå. Hva går dette utpå? Ber dere om hjelp? Er dere blitt flinkere til å fortelle andre om barnet deres, og hva slags behandling han/hun trenger?
5. Hva slags støtte trenger dere fremover i forbindelse med barnet deres? Hva slags støtte får dere nå og fra hvem? Får dere nok støtte?
6. Hva slags tanker har dere om barnets fremtid? Hvordan kan dere møte utfordringene som kan dukke opp, og hva slags utfordringer dreier det seg om?
7. Hvordan kunne Webster-Stratton-tilbudet blitt forbedret? Er det den riktige form for hjelp for barn og foreldre i en situasjon sammenlignbar med deres?

Kommentarer

1. Det er viktig at vi sikrer oss opplysninger om eventuelle hendelser/livsforandringer som har inntruffet etter at behandling tok til. Vi har mye systematiske opplysninger om familiene før behandling tok til, som skal legges inn i vår datasett. Eksempler på relevante forandringer er f.eks giftemål, nytt samboerskap, separasjon/skilsmisse, fødsler, sykdom i familien, skifte av arbeid, arbeidsledighet, dødsfall i den nære familien, flytting, påbegynte eller avsluttet utdanning.

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